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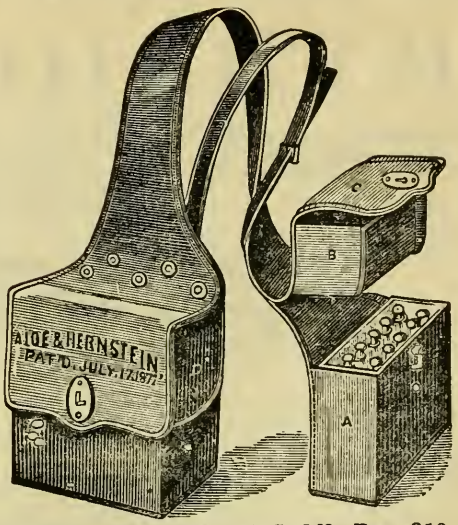

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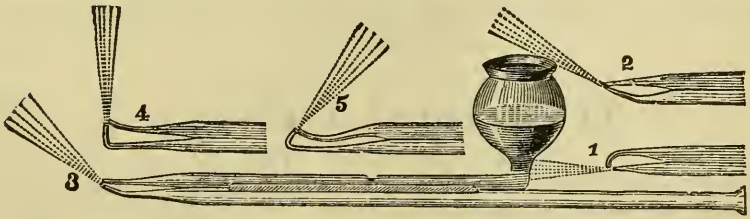

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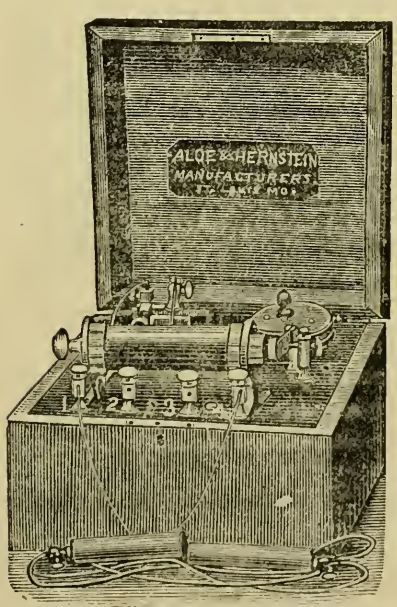

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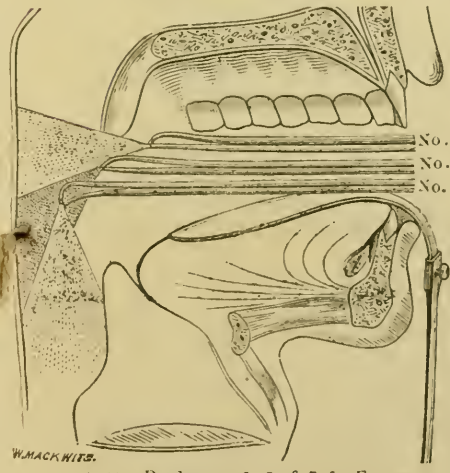

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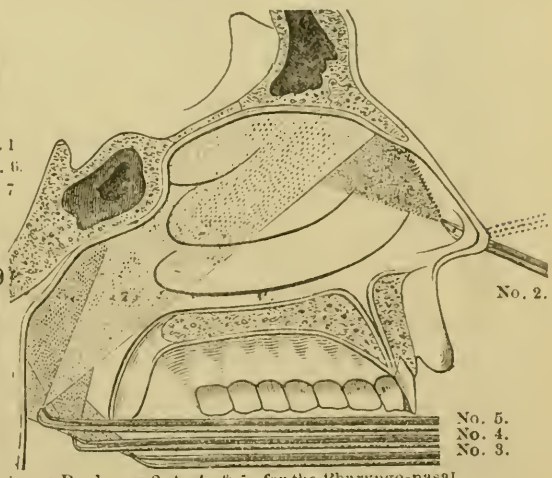

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*See note p. 64, Prof. VAN BUREN & KEYES on Urinary Organs.

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Vol: XLII. FEBRUARY, 1882. No. 2.

Original Contributions.

Article XIX.

Nervous Shock as a Therapeutical Agent. By Romaine J. Curtiss, M. D., of Joliet, Ills.

It may be true, scientifically, that all remedies addressed to the nervous system, as drugs and the galvanic current, act by producing a shock upon the nerve centers to a greater or less extent, and that the beneficial effect of these remedies may be independent of the cause of the disease. It is established that pain may continue in a nerve or set of nerves from habit after the cause which originally produced the disease has been removed and that the pain under these conditions may be removed by galvanism, which may be classed as a mild degree of shock. No verification is longer necessary to establish the fact that shock of the nervous system, from injury of the sensory nerves, or through the higher nerve centres from emotional excitement, is a factor of the greatest importance in the etiology of nervous diseases. Shock kills a large proportion of wounded persons who die from injuries, and the history of mental development is filled with instances of endemic and epidemic nervous diseases of the convulsive type which were the sequences of superstitious and religous emotional excitement. Death, idiocy, insanity and convulsions it is well known, result from the terrible shock the nervous system sometimes receives through the avenues to the brain, of fear or other emotions.

The importance of shock as a cause of nervous disease is granted, and it is easy from these data to infer that such phenomena, properly modified, and used as remedies have a very beneficial effect upon nervous diseases. The general induction I wish to make from citations of the following cases is: that nervous shock by drugs, electricity, etc., sometimes cures nervous diseases without reference to action on the cause of the disease, and that this law holds good in many methods of treatment now employed in the management of nervous diseases which are supposed to be addressed to the cause of the disease. I believe that

this view of certain nervous diseases, the cause of which is referred to the sexual organs, and the cure of which is referred to the surgical operations of circumcision and dilatation of the urethra, can be explained with greater satisfaction in this way, than by the induction attempted, and so violently disputed, that the nervous diseases in question are caused by preputial irritation and contracted meatus and the surgery of circumcision and dilatation removes the cause. In the cases of this nature already reported it must be conceded that the supposition given that the nervous disease—generally paralysis—is a sequence of the genital irritation is not verified, and if proofs cannot be furnished, it is probable that the cure, or apparent cure of the nervous disease, is due to the nervous shock of the operation acting independently of the cause of the disease.

In support of this view, relating to this open question, I will cite cases and discussions from medical authors as well as cases from my own practice.

CASE I.—Mrs. —— in 1879 when she became my patient, was thirty-two years of age. She had been divorced about four years, and while living with her husband six years, had one child and three miscarriages. The clinical history showed since her divorce she had been continuously in the care of physicians for symptoms referred to the pelvic organs. The first year she was subject to weekly applications to the uterus by an eminent gynæcologist of Chicago, for ulceration. I had reason to believe that the diagnosis was correct, that the remedy used was nitrate of silver, and that the ulceration was cured, though the patient declared she was not benefitted in the least.

The patient next consulted a medical gentleman who owns a homœopathic sign board, formerly a regular, and who advertises that he "doctors both ways," yet his treatment of this patient was neither way, as he subjected her to the operation for restoration of a perineum which was never lost; for the most critical examination by myself and another physician failed to find any evidence of perineal rupture or cicatrix of operation, except two round cicatricial warts in the skin, one on each side and just posterior to the vulva, which were probably made by inserting a wire, drawing the vulva together, and leaving things in *situ*, as the patient said, for two weeks.

I am convinced, from my own examination and opinion of

the physician who examined the case with me, as well as the statement of the patient herself, who, when questioned, said she could perceive no change in the anatomy of the parts, that the patient never had any degree of perineal rupture, and I concluded that the accomplished physician who made the operation, did so with the intelligent design of producing a nervous shock on the patient. The effect was good, as a therapeutical measure, for the patient declared that her subjective sensations of distress were removed, though they were not the symptoms belonging to a rupture of the perineum, and that for several months afterwards she thought herself cured.

However, when the patient consulted me, she was as "bad as ever." Her symptoms were: A burning pain in the pelvis, extending to the hips, and up the spine and abdomen, some rectal tenesmus, or rather as she described, a feeling of something pressing upon the rectum. This distress was not constant, but described a rhythm of about three weeks duration. During the paroxysmal periods, or when the pain was on, the abdomen would become greatly distended, and in addition to the burning pain and tenesmus, there would be a throbbing sensation throughout the pelvis. An examination of the uterus bimanually showed a depth of three and a quarter inches. There was no marked tenderness of the uterus or ovaries, nor visible discharge from the uterus. This was the condition when the pain was off. During the paroxysm there was general hyperæsthesia of vulva, vagina, uterus and ovaries and abdomen, and pressure in direction of cellular regions of the pelvis gave her great pain. At this time, also, blood vessels apparently enlarged, could be felt pulsating notably behind the uterus.

About this time I read a description, I think in Emmet's work, of a case somewhat similar in which a gentle elevation of the uterus would stop the pulsation, and the case was cured by a pessary, which held the uterus in just the right position. I now thought I had the key to the situation, and used temporarily a cotton pessary with very happy effect. I followed this up by the trial of nearly all pessaries of all sizes. When the patient had no pain or hyperæthesia she was contented with any pessary; but on accession of her paroxysm, any pessary had to be removed, and I finally gave up this view of the case, also, the pessaries. I then thought the disease might be due to the effects of malaria, and gave large quantities of quinine, also applying

quinine locally to the uterus, and gave rectal injections of twenty-five grains at a dose. For a few months this method promised a cure, but finally had to be given up. I noticed at this time a theory put out by a Baltimore physician which was, in substance, that most uterine diseases, if not all, were caused by a condition of venous congestion of the uterus by obstruction of the circulation due to stricture of the cervix, and that dilation of the cervical canal by bougies was the sovereign "balm in Gilead" for suffering woman. I thoroughly dilated the cervical canal by bougies, and other dilators without effect of permanent character. The next new light on uterine disease which attracted my attention, was a statement in some journal, that many obscure diseases of this nature were due to endometritis and the diagnosis could be made by applying a cotton tampon saturated with a solution of tannin over the cervix and examining the discharge collected with the microscope when, if endometritis was present, pus cells would be seen. I tried the method and on examining the discharge with Talles very best microscope, sure enough the pus cells were there. I now proceeded to treat the endometritis with comp. tr. Iodine, as recommended. I made all applications to the uterine cavity by means of a syringe having a long, slender, flexible nozzle, the distal inch of which is perforated with five holes, and which I wrap with cotton, and which combines syringe and swab. The applications were always more or less painful and were made every fifth day for about two months. At this time, for the first time since using this instrument, the cotton on one occasion became displaced in passing the cervical canal, some of the holes were uncovered, and I met with the calamity of producing a terrific uterine colic in my patient by injecting a drachm of the medicine into the uterine cavity. I need not describe the scene which followed, and which lasted for two hours, the patient refusing to take morphia. It is sufficient to say, that the patient received a nervous shock, the first since the homœopathic restoration of her perineum, and the second of the series.

After the accident the patient was free from her pain, tympanites and tenesmus for several months. But had during this time an attack of sciatica, and short session of *tic douloureaux*. At the end of about six months she returned and stated the feeling of pressure on the rectum had returned, though she had no further burning pain in back and abdomen, and her bloating from tympanites was as bad as ever. During this rest from labors, I

had read two articles by Dr. Sutton of Pittsburg, on fissure of the anus in male and female, describing the symptoms which fitted my patient as well as anything else did. The cases of cure were so graphically given, so convincing and so successfully treated by anal stretching, that I was confident my patient had an anal fissure, and that I had overlooked it. Dr. Sutton, when commenting on the benefits resulting from stretching the sphincter, remarked that equal benefit had occurred by the procedure even if there were all the pelvic symptoms of fissure, and the fissure not there. I made a very careful examination of my patient's rectum, turning it out by my finger from the vagina, and the fissure was not there. I nevertheless determined to make the operation, and gradually getting both thumbs through the sphincter I *eked* with all my might, and my patient received her third nervous shock, which, up to date, has proved to be sufficient. At the time of this operation the abdomen was enlarged equal to the full term of pregnancy by tympanites, which disappeared in a few days, and has not returned.

I am positive that the criticism of this case cannot be that it was one of hysteria, or "speculum mania." I regard the affection as having been *caso-motor* in character, probably originating from irritation of uterine organs following child-birth and miscarriages, and I think there was some, and had been more, pelvic cellulitis, and I also believe, now, that the series of nervous shocks she received by fraud, accident and design, cured her.

Case II.—Master J., aged six years, has for a year been unable to retain his urine when awake, more than half an hour. In fact, his mother states that he is continually making water. He is habitually pulling at the prepuce, which has become unnaturally elongated by this habit. The prepuce is not tight, but is retracted over the glans, and there is no lack of cleanliness. The urine was examined for deposits and proofs of cystitis, and bladder sounded for stone—all giving negative results. After sounding for stone the symptoms were relieved for a time, but returning it was deemed best to cut off the prepuce which was done, and was followed by recovery. To get at the chain of antecedents and sequence in this case, I made much persistent enquiry, and became satisfied that the first phenomena of this series was the habit formed by the boy of pulling on the prepuce, which was followed by a discharge of urine because of the pull, and not because of the length of the prepuce. I think the shock of the operation, as well as diminished length of prepuce, broke up the habit and the disease.

[TO BE CONTINUED.]

Article XX.

Medical Orthodxy.* By T. D. Washburn, M. D., of Hillsboro, Ills.

[concluded.]

Ethics.—Having satd this much, my impartial hearers are prepared to listen to a few suggestions on the vexed question of ethics—and here I must be brief. I will touch but a single point, consultations; and as open confession is good for the soul, I'll take the witness stand:

Query. Did you visit Mrs. N. in a neighboring village, when Dr. C. an eclectic was attending?

Ans. I did, and knew he was in attendance; she had, sometime before been my patient, wished to see me and I went. I advised a certain course, to which he assented, and faithfully carried out. He wrote me afterward and some modifications were made. I found him a well read man, ambitious in his profession, and quite willing to listen to advice from one who was not of his school. I met other cases with him afterward, and always found him well posted and reliable, willing to carry out my suggestions while having an opinion of his own. I have consulted with some of the regular school far inferior to him, both in native and acquired ability. I advised him in regard to certain authors of our school, and he expressed a desire to examine them, though I found he had a good library not confined to any one school.

2nd. Query. Did you visit that surgical case in Black Jack township and meet a homœopath?

Ans. I did, and found him as good an assistant as I care to have in a severe case like that. He took in the situation at once, and we harmonized completely. True I did not expect to meet him when I started; did not know he had been called, but it

* This paper and the discussion following it, form a part of the transactions of the Tri-State Medical Society, which met in St. Louis, Oct. 25th, 26th, and 27th, 1881.

made no difference. I met him again some time after, in one of his own cases, by his invitation. Prof. G. was up from St. Louis, and we talked the case over as though we were all from the same school, and I never felt very bad about it. He never calls me in a medical case, as he knows I have no faith in "little pills." And yet this ghost of ethics will not down! It is a fossil which marks the decrepitude of the age which made it. Do you consult with anything and everybody? No! But you may safely consult with men of brains, that take a pride in their profession; that give evidence of study and growth. Why muzzle the medical man with ethics that society does not recognize, or good sense approve? In this case we can risk the "survival of the fittest." Ordinary sense and common morality seem sufficient guides even for professional men. I admit a halo of reverance and smell of sanctity lingers around this venerable relict, but why worship dead rubbish? Here you must allow me to introduce Dr. Stone of Minn., who presided at the late meeting of the State Society. He gave the *code* such frightful blows, that he fairly excites our sympathy in its behalf. (See *Chicago Med. Review* of July 20.) He takes up *seriatim* the code and probes unmercifully its windy pretensions; and would you believe it, those northern ninnies had the effrontry to knuckle to the man, and by a rising vote present their thanks; worse than that, they requested a copy for publication in the *secular* papers (insult to injury); if this had happened in the warm blooded south, our feelings might not have been so fearfully shocked, but in the polar regions of Minn., where the blood only makes about two revolutions a minute, it betrays a depth of depravity wholly unexpected.

Dr. Leasure in his address of welcome, startles us by saying; "We have progressed quite as much in unlearning hoary errors, as in finding new truths." But President Stone, disavowing any "*carping spirit*," boldly utters the naked truth and says: "The code, since its final adoption has apparently been laid upon the shelf by the family bible, to be treated with almost as much reverence, to be used quite as seldom, and to be quoted only when its provisions enable one to discipline a rival, or to exclude him from the benefits of professional affiliation." "A judicial consideration of the code, forces the conclusion that much which it contains is gratuitous insult to the profession, and more is rather calculated to amuse, than impress with respect the mind

of the layman." The whole speech is replete with good sense. But lest you charge me with prejudice, I will summon another witness. I will not call the Hub, where we have some reason to believe the code is already embalmed and carefully laid away in granite, with some old veterans to stand guard, for fear it might break loose before Gabriel sounds his trumpet, but we will call her big sister, New York. The spicy "*Gazette*" speaking of professional etiquette in connection with the case of Beaconsfield, where Dr. Jenner declined, and Dr. Quain accepted a consultation with the attending homœopath, says: If the practitioner is to be guided by the code of ethics, the question hinges on the query, who is, and who is not a regular practitioner? The code answers this as follows:

'No one can be considered as a regular practitioner, or a fit associate in consultation, whose practice is based on an exclusive dogma, to the rejection of the accumulated experience of the profession and the aids actually furnished by anatomy, physiology, pathology and organic chemistry.' The laity who look at the subject superficially, regard with ridicule a doctor who refuses to meet an irregular when the interests, perhaps life of a patient may be at stake; * * * * * * * * Certainly the law here is not a rigid one, since it allows consultation with any practitioner whose practice is not based on an exclusive dogma. This does not seem to exclude homœopaths who practice allopathy, and which of them all does not?" (The same also can be said of eclectics.) "As long as human nature is imperfect, so long we must submit to be governed by a code of ethics; but as this is only the expression of the representative voice of the profession, it must necessarily change with the ever varying tide of opinion. * * * * * This tide he admits, is "setting strongly" towards *liberalism*, but advises a *happy medium* between the two extremes. This seems to be a foundation principle on which we can safely build, and the only tenable position for genuine orthodoxy.

When such distinguished minds as Herbert Spencer, exhaust the very fountains of erudition, giving us over 200 octavo pages on the subject of *ethics*, and still fails to formulate a code, or present anything more than general principles, adapted to the age' culture and peculiar environment; a sort of sliding scale, like a thermometer suited to the temperature and locality in which it is to be used; surely, we can afford to give some margin for a

medical code, and not make a procrustian bed for a tired doctor to sleep on.

Eighteen hundred years ago, a very distinguished class of men gathered around a prominent character and teacher, and propounded such grave questions as these: "Why do thy disciples transgress the tradition of the elders? For they wash not their hands when they eat bread." Is it not about time we quit asking such questions as these?

A distinguished author says: "It may be doubted, whether the human race can ever gain anything by departing from the principle of utility as the sole criterion of good, morality, and there is an increasing tendency to recognize the supremacy of this principle, both in morals and legislation." Now, if utility is the criterion and the *code* has ceased to be utilized only as a "cat o' nine tails," a weapon of discipline, let us bury the thing, and have President Stone pronounce its epitaph. Admit the code to be faultless, every word true; did it never strike you that it was more suitable for adolescence than maturity? But lest I am accused of injustic and some think I would rob them of any substitute for the code, allow me to advise the adoption of the "*new version*," and if this is too modern, our conservative friends might use the *decalogue*; these failing, why not adopt the Draconian code as a medium? While I have but briefly adverted to many points in these complex questions, I trust sufficient has been said to enable you to arrive at a few of the legitimate conclusions which must influence us in establishing an orthodox creed, and erecting a platform broad enough for all true men to stand on; while it rigidly excludes those who make medicine a mere trade, who enter it half fledged, as a mere matter of speculation, and pander only to the lowest elements of our nature, stimulated merely by dirty parsimony and filthy greed; from all such, "Good Lord deliver us."

I fear my time will hardly allow me to enter on the discussion of legislation. While this is a sort of "terra incognita," still the public sentiment of the country is evidently prepared for judicious enactments in this direction.

Missouri meant well when she placed on her statutes, the necessity of a diploma; but when immediately after she chartered a school in her proud metropolis for the mere manufacture of diplomas, a thing to protect quacks, under the guise of eclectic medicine, she made a great mistake.

Illinois made a grand advance when she made her Board of Health custodians of her views, for medical acquirements, and hedged quackery in less compass than any previous legislation; yet many find fault with even this substantial gain, and with facile pen abuse and torture both the statute and the board. Very easy to find fault gentlemen, but why not put in your claims for better specifications? New York has done still better, having the advantage of the experience and errors of others. The signs are hopeful that greater excellence will prevail, and beneficent and wise laws be formed on most of our statute books, regulating the requirements and practice of medicine.

In a new and rapidly growing country like our own, perfection in legislation could hardly be expected. False notions of freedom, old established customs and habits are not easily broken up, and gradual growth in this direction should satisfy us. We have no reason for discouragement, no excuse for flagging in our effort to sustain and build better than the Fathers. Those who have given attention to what medical legislation and enactments we have had, have not failed to discover a want of uniformity and equity in many of them. Some are premature; some lax and irrelevant, but grouping all the legislation of the last decade in one general summary, culling the best and rejecting the worst, we arrive at quite satisfactory results, which give much promise for the future.

Allow me here to commend to your favorable notice an article read by Dr. McLelland at the last session of the Ills., State Med., Society, giving a digest and summary of all medical legislation to date. It is a paper of real merit and deserves a wide circulation, and could well be made the basis of wiser enactments than any yet reached. Even Massachusetts might learn something from it and be able to formulate a law (for she has none now), which her worthy sons could endorse.

As charity should begin at home, but not end there, I will venture a few strictures on my own state, Illinois. The *ten year* clause of preliminary practice has undoubtedly been much abused, and not a few are in practice to-day, shielded by this, who are totally unfit. New York acted more wisely when she required at the close of two years more, a legitimate diploma, or authenticated certificate.

2nd. I think it entirely in the province of legislation to require that all students preparing to enter the study of medi-

cine should have a rigid examination in regard to their qualification and ability to use their mother tongue; evidence of a good English education should be demanded. I mean this; any one who cannot take some topic and fill a page of note paper, say 150 words, legibly written and properly spelled, should be remanded to the common school. He should not be allowed to study medicine.

3rd. The law of Illinois is evidently deficient in the proper legislation to enforce it. Some states leave it for the action of the grand jury; some specific rule should be provided. One more difficulty has been present which the Board are evidently trying to eliminate, and that is these spurious "jim-jam" schools which claim recognition and endorsement, when they know they are bankrupt and clumsy shams.

Of course, bogus diplomas should be squelched, and both the man who sells and the man who buys should be justly enclosed, like Dr. Buchanan, in prison walls. In looking over the field as presented by Dr. McLelland, extending from Maine to Texas, we have reason to rejoice that we are so much in accord, and are convinced that a little judicious conference would give us a national statute which would harmonize all true physicians, and all sects and systems worthy the confidence of an enlightened public. Could not our national association be beguiled into some conservative action in this direction, and make a doctor who would pass as current as a greenback from Florida to Minnesota? We should aim at no legislation that will do injustice to any one. It is quite as much the interest of the people that they be protected from incompetence and pretense, as that professional aspirations be guarded and fostered. The incapable should be shut out; the competent endorsed and sustained.

We believe the day is dawning; already the light of genuine orthodoxy is gradually penetrating the thinking minds of the profession and cautiously creeping into our medical literature, and making its mark on the ethics of the profession, breaking down the artificial distinctions and foolish traditions which like the sins of Adam have been handed down from generation to generation. Speed the day when the medical millenium shall arrive. Then the *allopathic* wolf shall dwell with the *homœopathic* lamb, and the *eclectic* leopard shall lie down with the *regular* kid, and the *medical* calf and *hoary lion* of the *college* and the *fattling* of the *city* shall feed on the same *ethics*, and eat science as the ox eats straw.

Article XXI.

The Rational Treatment of Pneumonia.* By J. M. Armstrong, M. D., of Edwardsville, Ill.

Croupous pneumonia is an acute inflammatory, infectious disease, with a natural tendency under favorable circumstances, to terminate in recovery, by a sudden crisis occurring on the fifth and seventh day in adults, and from the second to the fifth in children. There is probably not a disease that afflicts mankind that a more diversity of opinion, regarding the treatment to be pursued is advocated by the profession than in pneumonia. It has been the type of inflammatory diseases—the treatment of which has been the basis upon which the foundation was laid for the treatment of all inflammatory affections. The indications presented for treatment in pneumonia are to relieve pain and dyspnœa, reduce the heat, prevent the exudation in the lungs from coagulating, sustain the action of the heart and support the strength of the patient. Any treatment devised that will fulfill these indications, may very appropriately be called the "rational treatment of pneumonia." Such a treatment we propose to present to you to-day.

To relieve pain and dyspnœa and reduce the heat. When a membrane is inflamed, the pain becomes one of the most prominent features for the relief of which we must direct our treatment. The pain in pneumonia is from the involvement of the pleura in the inflammatory process. Respiration is therefore, painful and difficult, and the pain is aggravated or intensified in direct ratio to the amount of motion induced by the act of respiration. If motion can be restrained, pain will be diminished. Pain is also produced by the quickened circulation which not only augments it, but elevates the temperature of the body. We have now before us a patient whose breathing is hurried and difficult, who coughs at intervals, and complains of pain in the side, whose pulse is rapid and whose temperature is considerably elevated. The history of the attack, together with auscultation, developes

*Read before the Madison Co. Medical Society, July, 26, 1881.

the fact that he has pneumonia. The natural tendency of mankind when sick, is to recovery; particularly is this true in pneumonia, and the effort that nature puts forth to relieve the diseased portion, may be studied with advantage. If we could see the inflamed membrane, we would find its surface covered with a fluid closely adherent to it; a little farther on in the process, that fluid would be more abundant and dense. Nature is forming a splint to support the membrane, a covering, so that when the two membranes meet, they will not come in contact. A cushion will be interposed; motion will be lessened; pain will be modified by the interposition of this exudation. Nature is endeavoring to relieve the difficulty by preventing friction and giving the parts rest.

There are possible and impossible things in medicine as in everything else. It is poetical to say, "strike at the root of the disease," but practically, it is difficult and dangerous, if not impossible. On theoretical grounds, it is recommended that as the lungs and pleura were the initial starting point, that the remedies given should be selected with reference to their therapeutical effect upon these parts. "Strike at the root of the disease," and when the inflammatory action is suppressed, the effects upon the system arising from that diseased condition, will subside. This may be proper in some diseases, but in pneumonia it is not a safe practice. The proper thing to do in the treatment of pneumonia, is to take the patient where you find him, and lead him back to where he started from. The initial lesion in his case was an irritation of the lining membrane of the air tubes or air cells; congestion followed, then inflammation. The effect of this condition is to produce an accelerated pulse and develope heat, which are now the dangerous conditions. To relieve pain and dyspnœa and reduce the heat. Take a sheet—an old one—and tear it in two lengths, fold it three times, dip it in water at the temperature of 80° Fahr., and wrap it tightly three times around the chest of your patient; he may complain a little when it is first applied, but in a few minutes he will tell you that he feels so comfortable—at about this time you will be giving directions to have the wet, cold bandage reapplied every ten or fifteen minutes, or as often as the feelings of the patient may require it, and if you meet with the same success that has attended us of late, the directions will hardly be given before the patient will express a desire to have it renewed. By this pro-

cess you subdue the heat, relieve the dyspnœa, lower the pulse, lessen the respiration and reduce the pain to a minimum. The heat is subdued by the direct application of cold, the breathing becomes easier as the result, and pain is relieved by the bandage. The application of a bandage around the chest acts as a support to the respiratory muscles, reducingtheir movements to a minimum, compelling rest. In all other inflammatory affections the therapeutic influence of rest is well recognized and strictly enjoined, and although we cannot forbid our patient expanding his chest, we can reduce that expansion to a minimum by a properly applied bandage.

It may be stated as an objection to the bandage, that one of the dangers in pneumonia results from the non-aëration of the blood, and that by the application of a bandage around healthy as well as diseased structures, it would diminish the ingress of air into the healthy portion, and not a sufficient amount would come in contact with the blood, and thereby increase that morbid state.

If the free access of air into the air passages, in pneumonia, was a curative measure, why has not some genius invented a pump, by means of which air could be forced in, and if the deficient supply of oxygen was the cause of the carbonic acid poisoning, it could be very easily supplied. The fact is that this is not the cause of the carbonic poisoning, but the cause lies in another direction. The undue amount of heat, the influence of long continued high temperature upon the organism, affects the functions of the red globules, as carriers of active oxygen, and diminishes the oxidizing power of the blood. Carbonic acid accumulates until the alkalinity of the blood is changed, and the red globules die—necræmia. By the application of the cold, the heat of the blood is reduced, the red globules assume their wonted functions, carbonic acid is eliminated, and peace once more is restored in that disturbed organism. The bandage has nothing whatever to do with the entrance of air into the lungs, it merely prevents surplus mobility. The wet bandage has been renewed every ten or fifteen minutes for one or two hours; now let us see what we have accomplished. The patient was found with a fever, a temperature of 104° Fahr., pulse 120, respiration 30, very restless, suffering from pain in the side, accompanied and aggravated with a cough. We now have him with a temperature of 99° to 100° Fahr., pulse 90 to 100, respiration 18 to 24,

pain modified if not gone; cough loose and less frequent. Is there an arterial sedative, is there a hypnotic, is there a drug or earth whose therapeutic action is at the "root of the disease," that will accomplish such results? No! Having arrived at this point, it becomes necessary to prevent the already existing exudation in the lungs from solidifying, and sustain the action of the heart. Administer a medicine, not a combination of drugs, but a medicine whose action upon the animal economy will be to antidote or correct the many disordered functions that have arisen from one single cause—congestion of the lungs. If a child should eat a few berries of the common night-shade, that grows so abundantly in almost every yard in this city, the following symptoms will present themselves: fever, dryness of the mouth and fauces, difficulty in swallowing, suffusion of the eyes with dilated pupils, colicky pains, redness of the skin, optical illusions, singing in the ears, numbness of the extremities, gidiness, delirium and intoxication; farther on there would be coma, twitching of the muscles of the right side, and general convulsions, opisthotonus etc.; there would also be constipation, cough with quickenened respiration and dry sibilant rhonchus. The urine would be suppressed, the extremities cold. Here are a train of symptoms, that if they should occur in a patient from some hidden cause, like malaria for instance, in accordance with the prevalent practice, a drug store would be called into requisition to relieve them. There would be given a purgative, a febrifuge, a sudorific, a diuretic, an opiate, an hypnotic, an antipyretic, an expectorant, demulcent, together with all the adjuncts, counter-irritants, sinapisms, blisters and what-nots.

The patient might recover, but if so, it would be through the influence of one medium—the opiate, which would antidote or correct all the symptoms which had arisen from one single cause. Therefore give one medicine, the therapeutics of which will cover or antidote existing symptoms and permit the patient to recover without disturbing the quiet and peaceful restoration to their normal functions of other portions of the system, that may have been disturbed by the introduction of one exciting cause. All the symptoms and all conditions in pneumonia are the effect of one exciting cause. The effect of a cause may and does at times become a disease within itself, but until that condition is made manifest, let the remedies be directed to the source from whence the disturbance

aries. We are speaking now of internal medication, and do not refer to the fever or those conditions which are controlled, or ought to be by external applications. A medicine should be given that *will not* derange the digestion, irritate the stomach, acidify the blood, constipate the bowels, weaken the heart, paralyze the nervous system, lock up the secretions or depress the patient; but one that will aid digestion, preserve the alkalinity of the blood, strengthen the heart, support the nervous system, liquefy existing secretions and stimulate the patient, for new relaxation will follow the period of excitement. Have we such a medicine? Ammonium chloride. This salt is well known; it is not necessary to introduce it, its cheapness may be one reason why its therapeutic value in pneumonia is so little recognized; its medical properties are those of a stimulant; "it improves the appetite and gives a certain buoyancy to the spirits." It improves the appetite and aids digestion by giving up one of its component parts to the juices of the stomach, chlorine which very readily unites with hydrogen to form HCl, and the quantity that is formed, is not too much to prove an irritant, but just right to supply the want. It does not acidify the blood from the same cause, but counteracts the formation or accumulation of CO_2 by uniting with the different salts to form chlorides, it having a stronger affinity for the salts than the CO_2 which being the weakest chemical combination, is set free, and eliminated. In pneumonia, there is an absence or a diminished amount of the chlorides in the urine. The continued use of this salt supplies that deficiency. The urine loses its reddish cast and strong ammoniacal odor, and becomes natural in color, odor and quantity. The tongue does not become coated or dry and cracked, sordes do not collect upon the teeth. The liver performs its functions undisturbed, and the bowels move when the accumulations are sufficient and they are of the proper color and consistence. Consolidation of lung-tissue suddenly disappears, and resolution is rapidly established; dilirium never supervenes, that is "hardly ever," and critical periods are lost sight of. The patient improves hour by hour from the time this treatment is fairly under way. This, gentleman, is the treatment for croupous pneumonia. It may be necessary, however, to administer an opiate; if so, give it, and when it has done what it was intended to do, cease giving it. Under similar circumstances, it may be necessary to give a cathartic; if so, give it. The heart may at times fail; if so give

10 to 20 drops of digitalis, and watch its effect; if it has to be repeated in 12 or 24 hours, do so. To support the strength of the patient: for this purpose, use fresh, sweet milk, crackers, bread and butter, and season it with salt. There is another chloride, and a good one too. It will follow right along behind the other chloride and finish up what work its predecessor has left but partly done. A study of the therapeutics of these two chlorides, with reference to the indications that call for treatment in croupous pneumonia, will convince any one, we think, that little more will be desired, and nothing else, where the fever, pulse and respiration are controlled with cold water. In the treatment of catarrhal pneumonia, we use the same treatment. By the application of a cold wet bandage, last winter, we succeeded in reducing the following condition to nearly normal standard in thirty minutes: A young married woman, measles seven days; 2 A. M., pulse 130, temperature 102½°. respiration 83. This was in the practice of Dr. K—, of this city. A cold wet bandage was applied tightly around the chest, with the admonition to the patient to breathe slower and deeper. The bandage was renewed every ten minutes. In ten minutes the respiration was 65; in ten more it was 40; in ten more it was 28; pulse 100, temperature 99°; in one hour it was the same. The patient, of course recovered rapidly. This patient, from either real or imaginary exhaustion would have died in a very short time, if something had not been done to rouse her energies. Collapse of the lung would have certainly supervened. When a plug forms in a bronchus, there is but one way to discharge it, and that is to direct a stream of cold water at a point on the spinal column midway between the shoulder blades, or apply suddenly a cloth wrung out of ice water; the patient, from the shock, will make a violent effort to cough, and discharge the plug, and prevent collapse.

The dose of chloride of ammonium, is from two to four grains every hour, in water.

Article XXII.

NOTES ON CASES IN GENITO-URINARY SURGERY.

—Case No. V.—

Stricture near the Orifice and at the Bulb of large Calibre. Chronic Prostato-Cystitis.—Division of the Anterior Stricture.—Dilatation of the one at the Bulb.—Cure.

By W. Hutson Ford, M. D., of St. Louis.

February 26, 1880. Mr. S. G. Traveling salesman formerly, now a clerk in a wholesale dry-goods house. Married, with two children. No inheritance of gout, rheumatism or phthisis. Uses tobacco, but no wine or spirits. Had a gonorrhœa eight years ago, followed by a long continued gleet. No instrument ever passed into the urethra. Never had syphilis, though he bears a suspicious scar on the dorsum of the glans penis. Has a varicocele on the left side. Complains of easy fatigue, listlessness, wakefulness, indigestion and occasional swellings about the face of uncertain character and extent. Has never passed any blood. No pain before, during or after micturition. The prostate is somewhat enlarged and tender; the urethra hypersensitive. Just within the meatus, a contraction of 25 exists, and for two inches down, the canal is scarcely wider. 25 barely passes bulb, and then with much pain and a jerk. A well defined induration is felt in the roof at this point.

Feb. 27. Urine dark colored, very acid. No albumen. Sp. gr. 1030. No pus. Deposits an abnormal amount of mucus. Strings of mucus are suspended in it.

Feb. 28. c. s. 25 engaged in bulbar contraction but would not pass through. Chologogue pill to-night. Warm baths twice a week. Warm hip baths every night. Soda and Pareira infusion. Diluents.

March 2. c. s. 25 passed through bulbar contraction.

March 6. Anterior stricture divided to 35. 30 just passes through a contracted tract below. 25 passes well through deep contraction but rather tightly. Division of Anterior Contraction.

March 10. c. s. 29 passed easily through perineal contraction.

March 14. c. s. 29 passed easily. c. s. 31½ passed into, but not through the perineal contraction. The meatus is kept well open.

March 18. c. s. 31½ passed fairly through bulb with some urging.

March 21. c. s. 31½ passed fairly as at last introduction.

March 25. c. s. 31½ passed more easily.

March 30. c. s. 32 passed bulb, but not without sensible urging, and with a jerk. The meatus shows a disposition to close. Patient says he feels greatly better and stronger. Appetite and digestion excellent. Bowels are regulated with a cholagogue pill and saline aperient, once a week or so. Passes a full, round stream of water.

April 4. c. s. 32 passed almost without pressure. Orificial contraction freely incised again, as it had closed up to 29. This was brought about, not by incomplete division, but by the use of an erroneously numbered bulb for keeping the cut open; a No. 29 having been stamped 33 by the manufacturer.

The patient is greatly improved at all points.

April 9. c. s. 32 passes easily. c. s. 33 passes through bulb. B. B. 29 passes with difficulty. The urine is decidedly acid, and deposits a thick layer of pus. The orificial stricture is well healed. Pareira Brava, and Bicarb. of Soda. Recurrence of Symptoms.

April 13. Urine greatly improved, nearly clear, slightly acid; general condition very good. B. B. 29 passes bulb with some grasping. c. s. 32 enters the bladder.

April 16. B. B. 29 passes bulb with some difficulty. c. s. 33 passes bulb with tolerable ease. He is much improved in health and appearance.

April 19. c. s. 32 passes easily through the bulb. He is so much better, that with general directions, especially as regards diet and the use of the sound, he was discharged. Two months later he still continued well. Recovery.

Translations.

Article XXIII.

FROM THE FRENCH.

Excerpts from Late French Journals. [Translated for the Journal.] By A. H. Ohmann-Dumesnil, A. M., M. D., of St. Louis.

Electricity in Uterine Diseases.—M. Hélot, of Rouen, speaks highly of this method of treatment in chronic engorgement accompanied by prolapse. He states that the uterine catarrh has disappeared under the influence of the changes brought about by the current, and that he has never felt the necessity of making applications to the neck in order to see the ulcerations disappear.

The apparatus consists of 12 Gaiffe elements, 15 centimetres high, (chloride of zinc and oxide of manganese), a rheostat, a Trouvé interrupter and a galvanometer divided into milliwebers.

The author thinks himself justified in making the following conclusions:

1st. The uterus, under the influence of electric currents, presents plainly contractions, not only during pregnancy or immediately after delivery, but also in an empty state.

2d. The contractions can be made visible in certain pathological conditions where a mucous plug in the cervix retains the secretions of the uterus. The contraction drives out this index, which takes its former position as if aspirated, when the contraction has ceased.

3d. The contractions may be obtained by a Faradic current, interrupted a great many times in a second; but this method is painful and its use ought to be limited to post-partum hemorrhages.

4th. Galvanization by interrupting continued currents provokes this contraction in a more favorable manner, because it

causes less pain and because there is added to the mechanical effect the electric action of the pile, rendered harmless by the frequent change of chemical action into motion.

5th. The maximum of useful effect has been produced with a current of 25 to 30 milliweber interrupted each second for a very short space of time.—[*Paris Médical.*

CHLOROFORM FOR ANÆSTHETIC PURPOSES.—M. Lucas-Championnière, struck with the difference seen in the chloroforming of different patients, concluded that they were partly due to the susceptibilities of patients and to a greater extent to difference in composition of the chloroform. Accidents may be due to impurities in the liquid. Having submitted several samples, taken from hospitals to M. Yvon for analysis, the latter without discovering impurities with ordinary reagents, found the boiling point different. Placing the chloroform for a certain time, in contact with permanganate of potassium and distilling it, gives an article having the advantage of rapidly inducing anæsthesia and allowing a safe recovery.—[*France Médicale.*

SECTION AND LITHOLAPAXY.—M. Zancarrol, in a memoir containing the record of a large number of operations, one hundred and four of extraction of stone by section, and eighty-four by litholopaxy, practiced at the Greek Hospital, in Alexandria, Egypt, a country where stone in the bladder is of very frequent occurrence, establishes a comparison between section, lithotrity and litholopaxy. From his experience he concludes that the last is by far the best operation.—[*Gazette des Hôpitaux.*

OVARIOTOMY DURING GESTATION—M. Galenvaux has practiced gastrotomy eight times. Once death followed, the complete removal of the uterus and ovaries. Of the other seven, five were enabled to resume their daily vocations, in two weeks. The two remaining cases were operated during pregnancy and made perfect recoveries, the gestation going on to term. The tumors were rather abdominal than ovarian and pediculated.—[*Bull de l'Acad. Royale de Méd. de Belgique.*

PROPHYLAXIS OF DIPHTHERIA.—M. Decroizelles proposes the following for hospitals, the numerous deaths of internes that have lately occurred, having drawn his attention to the subject.

Numerous carbolic acid sprays should be kept going on in the diphtheria wards, although the object is not exactly the same as in surgery.

The greatest cleanliness must be observed in wards, ablutions must be easily accomplished and all products coming from the diseased should be immediately destroyed.

For autopsies, at least, the respirator of Herrot Rheinus (which is provided with a mask) should be employed.

All physicians should adhere strictly to a certain dietetic and hygienic course, and to obtain better hygienic conditions, internes should have increased salary to be enabled to spend more on their apartments. Internes ought never to be allowed to see their patients before having partaken of a breakfast.—[*Revue Médicale.*

INTOXICATION FROM RUBBER.—An infant attacked with impetigo of the face, was ordered a rubber mask. The child soon had vomiting, diarrhœa and extreme prostration, which could not be accounted for. The rubber mask was removed, and all the symptoms disappeared. It is probable that there was poisoning by sulphide of carbon with which some rubber cloths are heavily impregnated. This is proven by the fact that a gutta-percha mask being substituted, no outward symptoms came on.—[*Journal de Med. et de Chirurg. Prat.*

STATE OF NERVES AFTER DEATH.—Charles Richet, in a communication to the Société de Biologie has made the statement that, after the death of an animal, the sensory nerves continue to preserve their functions for a longer time than the motor nerves.—[*Gazette des Hôpitaux.*

MICROBION OF MUMPS.—Capitau and Charrin have made researches on the pathology of parotitis. Repeated cultures made in Liebig *bouillon* with the blood of thirteen patients, have always showed the same forms (small rods, from two to three q and micrococus) and similar in aspect to those contained in the blood. All possible precautions were taken to guard against errors.

The saliva contained a large number of organisms, but as they are also met with normally, no importance was attached to this fact.

Urine taken at the middle of micturition contained nothing; but in one case there was observed the presence of retractile albumen and numerous microbia intimately connected with those of the disease. This is perhaps another case of infectious nephritis to be added to the twenty-four already known.

In conlusion: the blood of the parotid in mumps, contains organisms; they are genuine microbia, as they can be multiplied by culture. It remains to reproduce the disease by means of inoculations from cultures, which the authors have up to this time attempted in vain.—[*Ibid.*

THE FINAL PERIOD OF EXCRETION OF URINE AND SPERM.—M. A. Guérin does not speak of the action of the bladder, but when the urine has arrived in the urethra, how is it projected outwards, at least the last few drops. It cannot be admitted that the bulbo cavernous muscle is sufficient.

The following are the conclusions of this interesting paper:

1st The bulbo cavernous muscles are insufficient to fulfill the functions that physiologists have attributed to them.

2d. They act only through the medium of the blood contained in the bulb.

3d. The blood, under the impulse given by the contraction of the bulbo cavernous muscles, presses the mucous membrane of the urethra from behind forwards, thus accelerating the jet of urine, when the contraction is moderate, and so as to eject the last drops when the contraction has arrived to that state which has earned for it the name of *coup de piston*.

4th. The excretion of sperm is insufficient each time that the circulation of blood from the bulb towards the glans is intercepted.

5th. This theory explains the spasmodic strictures of the urethra and enables one to foresee that men cannot be catheterized as easily at the instant of turgescence of the spongy tissue of the urethra.

The author then added that this explained why men were always catheterized with the greatest difficulty by students of the opposite sex—[*Bull de l'Acad. de Méd de Paris.*

Article XXIV.

Cold Abscesses; their Nature and Treatment. By F. Leprevost. Translated from *la Revue Médicale Francaise et Etrangère.* By Wm. G. Eggleston, M. D., Hampden Sidney, Va.

To the old definition of cold abscesses, "*purulent collections, which have developed slowly and quietly, often without pain, in the cellular tissue,*" micrographical studies have added a new element, important in an anatomico-physiological view, which materially modifies the nature of these abscesses. That which characterizes more particularly these liquid tumors, is the constant presence of an enveloping membrane; a membranous sac, resembling ordinary cyst sacs.

This isolated wall or partition has not escaped the notice of observers; on the contrary its nature and rôle have given rise to a great number and variety of interpretations. Whilst that membraniform layer is by some considered inert, purely passive, and resulting from a thickening of the surrounding tissue by the gradual accumulation of the purulent liquid; others, convinced by the labors of Hunter and Chaussier, see in that membrane a product of the secretion furnished by the vessels of the affected region; or again, the result of the infiltration of the neighboring tissues by the plastic elements of inflammation.

For Ev. Howe and Delpech, this pseudomembranous coat possesses a high importance. That is, says Demonvilliers, a new organ which ranks high in the vital economy, which secretes, absorbs, sometimes manifests sensibility, and can under certain conditions, be influenced by the state of the principal viscera, and react in its turn on the rest of the organism. Of all the properties manifested by it, the most remarkable are, its continuous absorption and its secretion of pus in its cavity.

It has been rightly termed a *pyogenic membrane.* M. Lannelongue has explicitly defined the rôle of this membrane. If one examines a child with a cold abscess, taking care to examine it naked, and minutely explore the whole cutaneous surface, a small

swelling will often be found at some place, sometimes as large as a pea. In certain cases it may be superficial and easily found; more often hid among the tissues in the thickness of the muscles, it escapes observation until growing, it shows itself externally. Gradually the little nodule enlarges; from hard to soft, and finally becomes fluctuating. These little growths have received at the Saint Louis School the name gummæ. M. Lannelongue calls them *tuberculomes*. M. Brissaud and Josias have in fact, demonstrated their tuberculous nature. They are made up of an aggregation of tubercular elements; but they soon undergo transformation and modification. As soon as the peripheral layer of the embryonic cells becomes active, infiltrating and invading the tissues, the central part of the tumor softens. It loosens itself in consequence of the granular alterations undergone by its constituent cells. So that the tumor primarily solid, gradually gives place to a more or less liquid collection, surrounded by a resisting sac.

The abscess is now formed, but how does it grow? It was formerly entertained, that the puriform collections, slipping along the aponeuroses, traversed the spaces of the cellular tissue, favored in their progress by the muscular contractions, and the arterial beats, developed often by the force of gravity and the declivity.

That likewise explains the migration of those voluminous mediastinal abscesses which point out a great distance from their origin. But, we also notice now, not only the cold abscesses, properly so-called, but also conge tive abscesses, which are only cold abscesses occasioned by an osseous lesion.

Undoubtedly the conditions of the tissues, of the weight and declivity secondarily affect the development of the cold abscesses, but the reason *sine quâ non* of the development of the abscess rests in the limiting membrane itself.

To convince any one of this it is only necessary to examine the intimate structure of this membrane.

If after having applied an Esmarch's bandage to prevent a hemorrhage, we make by a straight or curved incision in the lower portion of the cold abscess, a kind of window, so that after evacuation of the pus, we can examine the internal surface of the cavity, we see that it presents an ill-looking appearance, uneven and rough, covered with rounded eminences resembling granulations with pale projections and prominences like the papillary

muscles of the heart. The color is greyish but not uniform. Here and there we see roughened ecchymotic specks or spots. Sometimes we may see spontaneous hemorrhages.

The cavity of the abscess is sometimes regular, ovoid or cylindrical, sometimes broken and partitioned off, divided by bows or floating membranous bands. When the abscess is small, we may with patience decorticate it, as in case of a sebaceous cyst. We see then, that the external surface of the pocket, smooth and united to the vicinity of the aponeuroses, presents among other things, small conical or conoidal prolongations, true granulations, comparable to the soft vegetations of wounds: these exterior vegetations, as M. Lannelongue remarks, like the vessels penetrate the surrounding tissues. "They insinuate themselves in the normal orifices of the fibrous tissues of aponeuroses for example, and on taking out the pocket, one notices the abnormal and unusual orifices made by the penetration of the granulations, in the normal vascular orifices, dilated by the granulations. The same appearance presents in the periosteum. When the cold abscess stops, as in the foot, in the ligamentous and fibrous tissues, the vascular prolongations, veritable granulations, penetrate in the intervals of the fibrous tissues, and sometimes insinuate themselves very far from the pocket proper; they form the fungous and faintly red prolongations, which it is important to recognise so that the whole may be excised. This is an important point regarding these simple cold abscesses, because for the osseous abscesses which form in the same region, the condition is still more remarkable, and the pouch sends on every side its prolongations." The above throws a living light upon the mechanism of the growth of the abscess. That it is not a passive act resulting simply from distension of the pouch. It is an active mechanism, a vital act, a gradual invasion, prior, furthermore to the presence of pus in the cavity.

The very remarkable differences which distinguish microscopically, the outer and inner surfaces of the pouches (pockets) are furthermore recognized and determined difinitely by the microscope. "Within, on the side of the cavity, the organic elements are the subject of a continuous work of disintegration and destruction which results in an augmentation of the contents. Without, in the tissues, there exists on the contrary, a proliferation full of activity joined to an organization more or less advanced, which has only time to arrest in the local instances,

proceeding from obstacles drawn from the same texture of these tissues. And in the interval between these two limits, the elements follow one or the other of these tendencies, or they decay and their *débris* collects in the cavities, in the tubercular follicles; or they unite and form solid tissues, such as one sees about the walls of certain vessels for example." Returning again to one definition, we say that cold abscesses *are purulent collections developing slowly, succeeding to solid tumors of a tuberculous nature and increasing by the proliferation and simultaneous destruction of their enveloping membrane.*

Since the limiting membrane of the abscess is not only the agent of the development, but its cause of existence (*raison d'être*) the *destruction* of this membrane is what should engage the attention of the surgeon. Puncture, irritating injections in the sac, are only as the results of the old practice have shown, illusory means to open widely the sac and take out by scraping or decorticating all the proliferating coat or lamina is the efficacious practice which should be adopted. We should treat in this manner, not only simple cold abscesses, but also the vast collections symptomatic of osseous lesions. Doubtless we should hesitate, to attack with the bistoury, a congestive abscess which has not reached the limits of the abdominal cavity, but we can at least follow the example of Lister, Lucas-Championnière and Lannelongue and make a large incision into the canal portion of the sac when it exists. After having opened the cavity of the abscess at its lowest portion, we proceed to empty it with a slightly dull instrument—the handle of a knife, for instance. The bent finger introduced may serve as a good scoop or scraper. We may also draw the edges of the membrane out, if otherwise, difficult of extirpation.

When the sac is emptied completely, we should wash out the cavity with disinfectant liquids. Strong carbolic acid sol. 20 per cent., and gradually weakened, fulfills the indications perfectly. A drainage tube is placed in the cavity and daily injections are made until the purulent discharge ceases.

So far, the results of this method have been most satisfactory. In no case have the accidents usually found, followed; the hemorrhage is insignificant. The only complications thus far observed, were two cases of erysipelas which presented no difficulty.

Article LXXXV.

FROM THE SPANISH.

Study of the Etiology and Nature of Beriberi. By Dr. A. Pacifico Pereira. Translated from the *Gazeta Medica da Bahia*, for the Journal. By Joseph Workman, M. D., Toronto, Canada.

[concluded.]

The influence of all that conjunction of circumstances which must infallibly produce anoxhæmia and develope Beriberi, did not escape the medical sagacity of the distinguished surgeon o the *Vital D'Oliviera*. On page 104 of his report he says:

"Nothing but entrance into port could have alleviated our bad situation. In reality after the death in the hospital of the three above mentioned beriberics, nothing further of note happened. A few, while in port, entered the infirmary (? of the ship), but from enquiry I learned that they had suffered on the voyage, fearing to become my patients, because of the great number already laid up. The disease presented its three forms; the mixed was that which was most destructive, killing some and sparing others severely attacked. The Beriberics remaining on board improved quite manifestly, after being permitted to go ashore for recreation."

The report states that the bad hygienic conditions were further aggravated by the very bad system of scrubbing in our ships of war.

"Dry scrubbings," says Dr. Galdino, "are seldom employed; the most common way is to flood with salt water, and to wipe off with mops. This system although not inconvenient when adopted on the upper deck, has very hurtful effects, when employed in the lower lodging compartments. The sea water deposits a large quantity of saline principles, which are absorbed by the timbers; these, in their slow evaporation, keep the air moist for a long time."

"In our voyage the results of these washings were per-

nicious in the parts under deck, which were almost every day at uncertain hours, inundated with salt water; there was a constantly humid atmosphere; the men breakfasted and dined with chilled feet. More than once, having necessity to visit the infirmary in the night, I found the bed covers very damp; this was the result of the evening washings which were completed at bedtime. I complained against this abuse several times to the commander, but to no effect."

"At Hong-Kong, where the hygrometer showed 100° of moisture, two wet scrubbings per week were made below."

The editor of the *Gazeta Medica* after closing his extracts from Dr. Galdino's report, of which I have here introduced only a small part, quotes at some length, from an article published by Dr. Silva Lima in 1876, on Beriberi, which is in complete accord with the views of the Brazilean surgeon. The following is the closing paragraph.

"It is well understood that these conditions," (humidity, bad ventilation, overcrowding, etc.,) "do not constitute the cause of Beriberi; but whatever this may be, they very effectually favor its activity."

The editor states that, "in Bahia he has at different times seen true epidemics of Beriberi, which limited themselves preferably to seminaries, the house of correction, barracks and war ships stationed in the port." "In Pernambuco it was in the house of detention that circumscribed epidemics were most frequently observed. In India, also, grave epidemics of the disease occur in the prisons." In relation to Beriberi in the prisons of Japan, Dr. Simmons makes the following observation:

"Although Beriberi in India is particularly grave in the prisons, it is infrequent in those of Japan, where they are simple but substantial structures of wood, with the best possible ventilation, whilst in India they are of stone, and are damp and badly aired; the humidity is, in my opinion, a powerful predisposing cause."

We could add, continues the *Gazeta*, innumerable observations showing that it is a fact fully confirmed by the testimony of physicians, that the crowding of individuals in damp and badly aired places, is a predisposing cause of Beriberi; we shall, however, cite merely the observations of Dr. Anderson, as given by Dr. Simmons, and made among the Japanese who lived in the docks at Yokohoma:

"Of 300 men, 70 were attacked, of whom 20 died rapidly, and 47 were sent to the marine hospiptal at Tokio. The food, clothing, or employment of these men, offered to observation nothing extraordinary; but they slept in a locality in which, by reason of the sheltered anchorage, the air was almost stagnant, and hardly 32 cubic feet was given to each man. Change of lodgement, especially that for sleeping, put an end to the epidemic."

I cannot extend this paper so as to present more fully the valuable observations of Dr. Pacifico Pereira, whose essay has extended through several numbers of his journal, and is not yet all published. It will be observed that the extracts which I have made, nearly all relate to the etiology of the disease alone.

In the July No., of the *Unino Medica* of Rio de Janeiro, a series of very interesting autopsic details of cases of fatal Beriberi, quoted from Dr. Pereira's article, are given. I must confine my extracts to only one case, as follows:

"Autopsy 12 hours after death. F. aged 36, of regular stature, well formed and muscular. Cadaveric rigidity of light degree in the finger joints; general subcutaneous infiltration, more notable in the lower limbs, in the thoracic wall, and the neck and back. Cyanosis in the face and extremities, but particularly in the lips and finger points. Large livid blotches on the ears, the neck and the arms, and strongly accentuated and extended on the back.

CRANIAL CAVITY.—The diploë of the bones engorged with dark fluid blood; an effusion of about 60 grams of serum in the cranial cavity; the superior longitudinal sinus, containing little blood, the lateral sinuses and those of the base engorged with black blood, with small coagula floating, which were easily broken up.

The vessels of the meninges generally full. In longitudinal and transverse sections of the cerebral hemispheres, a fine punctiform injection was seen through the whole thickness, most notable in the white substance. A small quantity of serosity in the lateral ventricles. In the medulla oblongata and spinalis, slight hyperæmia.

THORAX.—The diaphragm over both sides, at the the height of the fifth rib. In the two pleural cavities about 800 grammes of serous liquid, limpid and yellowish. The lungs a

little retracted in form, without any pleuritic adhesion; ashy aspect, paler on the front, darker in the back of the lower lobes, and giving out on cutting, a sanguinolent liquid, dark, and mixed with air bubbles. The bronchial mucous injected and covered with mucosity. The jugular veins a little turgid, containing dark, fluid blood. The pericardium contained about 70 grammes of transparent yellowish liquid. The heart was a little larger than normal; the left ventricle contracted; the muscular tissues of the whole organ of a pale yellow; near the vertex a notable quantity of fat. By dissection in the whole thickness, the muscular texture was seen discolored and yellowish, especially in the papillary muscles. The left ventricle, nearly empty, a few soft, dark coagula which separated readily on light pressure. The right ventricle contained a greater quantity of blood, dark and black coagula somewhat consistent. One large coagulum of about ten centimeters in extent, reached from the trabeculæ of the right ventricle into the pulmonary artery; and another smaller, from the right auricle into the inferior vena cava. These coagula, obscure and different in their superficial parts, were more consistent towards their centres and yellowish, and as if infiltrated with serosity. The sigmoid and auriculo-ventricular valves normal. The muscular texture of the heart was easily torn by the fingers.

ABDOMINAL CAVITY.—Contained about 600 grammes of yellowish, transparent liquid. The epiploon and the mesentery had a large quantity of fat. There was hyperæmia of the epiploon and the intestines.

THE LIVER, was voluminous, weighing 1600 grammes (4lb 5½ oz.), with a longitudinal diameter of 28 centimeters (11 in)., transverse 19. (7½ in.,) and its greatest thickness 10. (3 4–10 in). The surface was covered with yellow spots, more or less extensive, notably larger and deeper on the lower face. On closer examination it was seen that striæ of yellow color formed a network very fine and irregular, circumscribing small, darker points. On section there were seen on the surface of the cut, striæ and yellowish points, contrasting with the small and darker ones. The section gave a flow of dark blood, fluid and sensibly mixed with fat. The consistence of the texture was inferior to the normal; it broke up readily on pressure.

GALL-BLADDER, slightly adherent to liver, and containing a great quantity of blackish, thick bile.

SPLEEN, 15 centimeters long, 9 broad, and 5½ thick. Weight 220 grammes (9½ oz.). The surface obscure, of vinous tint; texture friable, little resistance, lacerating on pressure. The pulp of intensely violet color, engorged with dark blood.

PANCREAS, nothing abnormal.

KIDNEYS, rather enlarged; easily detached from their capsules; the surface smooth, of dark, yellow color, with yellow spots and striæ more or less extended. On dividing by a sagittal section, the surfaces of the cut were seen yellow in the cortical zone, and as if pricked with dark points, and of a paler color in the medullary portion.

THE BLADDER, contracted; a very small quantity of turbid, yellow urine.

THE STOMACH contained a large quantity of thick, dark liquid; the mucous coat was injected, and presented a fine punctuation, due to numerous very small hemorrhagic foci. In the duodenum and jejunum the mucous coat was slightly injected. The aorta and vena cava inferior showing nothing abnormal.

THE MICROSCOPIC EXAMINATION.—In the liver, hyperplasia of the perilobular and interstitial connective tissue was seen; also degeneration of the cells of the proper texture of the liver, which presented a protoplasm full of small fatty granulations. Around the vessels there were also hyperplasia of the conjunctive tissue, forming perivascular fasciculi, equally infiltrated with fat.

In the heart there was entensive fatty degeneration. The transverse striæ of the muscular fibres had completely disappeared in many fibres, and were substituted by fatty granulations; in others, the striæ were yet visible, but interrupted from space to space by the same granulations. In both the internal layers next the endocardium, and the external next the pericardium, fatty degeneration more or less advanced, was seen in the muscular fibres. In the papillary muscles the fibres were degenerated in a high degree. The large coagula met with, were formed in the center by a dense reticulation, constituted by filaments of fibrine containing discolored cells, and were infiltrated with fat cells in great quantity, and fine granulations of fat.

In the kidneys the protoplasm of the epithelial cells of the canaliculi was full of granulations the interstitial texture was infiltrated with fat cells and granulations.

In a portion of the texture preserved in alcohol, the canaliculi were seen at many points void of epithelial cells, and at other points they appeared separated and retracted. The conjunctive perivascular pyperplastic tissue was also infiltrated with granulations and fat cells. In the spleen, were seen venous hyperæmia, dilated vessels, small hemorrhagic foci, globules of blood and pigmentary cells, accumulated in groups, in greater or less number in the pulp.

THE CEPHALIC SOUFFLE.—M. R. TRIPIER, Physician to the Hospital of Lyons, has published some new researches on this subject. He believes that in certain cases a deep systolic souffle can be heard all over the cranium, but principally at the sides on a level with the temples, and with a maximal intensity over the right temporal region. It can be modified or momentarily suppressed by compression of the carotid of the auscultated side or even of the opposite. The patients with whom it is observed themselves hear the intermittent bruit. It is most probably produced at the terminal part of the carotid artery, where it enters the cranium. It is most frequently met with in cases of anæmia produced by hemorrhage or cachexia, and in chlorosis; and where it is heard without any bruit at the base of the heart, and especially where it is heard without anæmia, there should be a suspicion of pressure from intra-cranial tumor.—[*Revue Médicale.*—[*Dublin Journal Med. Science.*

Original Lecture.

Article XXVI.

Puerperal Eclampsia. By G. M. B. Maughs, M. D., Profesor of Obstetrics and Gynæcology, in the Missouri Medical College at St. Louis.

The subject of this lecture is puerperal convulsions—eclampsia puerperalis. This is one of the most dangerous accidents that invades the lying-in room. The affection is peculiar to the pregnant condition, and may happen during the latter stages of pregnancy, during labor, or immediately after labor, during the puerperal condition. The affection has been divided by authorities, into epileptiform, hysterical and apoplectic convulsions.

None of these belong to eclampsia puerperalis, it is a disease *sui generis* and belongs of course to the essential conditions of the lying-in-child-bearing woman. Its causes have been the matter of much research and controversy. It was supposed by the older writers to be an apoplectic seizure, the result of congestion of the brain; but after the discovery of Lever and Frerichs, of albumen in the urine in connection with eclampsia, it was supposed to be the result, not of albuminuria, but of the presence of urea in the blood.

Braun, noticing that albumen in the urine was nearly always associated with eclampsia puerperalis, as it is in Bright's disease, supposed that Bright's disease was the cause of eclampsia. Halbertema supposed it to be the result of urea in the blood simply, without attributing it especially to Bright's disease, the two conditions of albumen in the urine and urea in the blo d, being as he supposed, the result of pressure of the uterus upon the ureters.

As before stated, Braun supposed the etiology of the puerperal eclampsia was very clear in that it was Bright's disease of the kidneys; but numerous observations demonstrated the fact that three were many cases of Bright's disease of the kidneys without

any eclampsia, and that some cases of eclampsia were attended with no evidence of Bright's disease of the kidneys. It was clearly demonstrated that in a great many cases, there was no albumen in the urine, and that while very frequently there was found albumen in the urine, and therefore urea in the blood it was supposed to result in these cases from uræmic poisoning. Then again it often happens that we have albumen in the urine without eclampsia. Yet the two are very intimately associated, inasmuch as it is the law, that if we have no albumen in the urine previous to the attack, we nearly always have it after the attack. So that the two are intimately associated.

The albumen in the urine, and the urea in the blood have been supposed to result from the same cause as the convulsion, or else the albuminuria produces the eclampsia; or else the eclampsia produces the albuminuria. So that it is not possible to say which is the cause, and which the effect. Most probably both are dependant upon the blood state.

The premonitory symptoms of the attack are important. It will be found in almost every case, upon a careful examination, that there is œdema of the eyelids and upper extremities. Œdema in the pregnant woman is usually in the lower extremities; here it is common in the pregnant woman, and is a result of the pressure upon the pelvic blood-vessels, preventing the return of the venous blood from the lower extremities; but œdema of the face and upper extremities in the pregnant woman, is a symptom of more gravity, for there is generally a condition of albuminuria. With œdema of the upper extremities we have, not unfrequently, a disturbed vision, flashing of light, mists floating before the eyes. These are often associated with serious headache, some impairment of hearing and nervous disturbance. These symptoms would be of great importance, and should lead at once to an examination of the urine. Indeed, if the pregnant woman complained of these symptoms, it would be criminal neglect not to at once examine her urine.

A very ready test of the urine to discover the presence of albumen is to take a small quantity in a test-tube, and pour some nitric acid down the side of the tube. As it is heavier than urine, it will immediately run down to the lower side. Upon looking at it, you will see the lower portion, pure, nitric acid, in the upper part pure urine, and if there is albumen, the middle is

cloudy. If you shake it, it becomes cloudy throughout the tube. If you place such urine in a test-tube and heat it, it will in severe cases, become cloudy,—semi-solid—coagulated. In lighter cases, flakes of cloudy albumen will be found throughout the tube. If you find albumen in the urine, you will treat the patient as previously, instructed for albuminuria. Or the patient may, without any of these premonitory symptoms, have a violent eclamptic seizure at the beginning of, or during labor. Or, she may at this time be seized with apoplexy or epilepsy. It would be improper to call either of these conditions apoplectic or epileptiform eclampsia. Neither of these diseases have any relation whatever to eclamptic apoplexy, while a convulsive disorder may happen without any convulsion at all, being a paralysis from the beginning.

Epilepsy, the type of convulsion, might in a simple attack, be mistaken for eclampsia; yet is a distinct disorder, and has a different history.

There is this difference of diagnosis: A woman may have an epileptiform seizure without having had any previous attack, and she may have none afterwards, though this is unusual; whereas, the eclamptic convulsion has not been preceded by any other, and will repeat itself immediately. The attack then may be ushered in without any premonitory symptoms. It happens that the vost majority of these cases happen during labor; of three hundred cases, two hundred have occurred during labor. Fifty perhaps, happened in the last stages of pregnancy, just preceding labor. Fifty more, in the puerperal condition, after labor. The seizure is one of the most frightful phenomena that can present itself, alarming the attendant himself, unless he is prepared for the occasion. The attack generally presents itself in this way: first, there is a tonic spasm of the chest, with a fixedness or rigidity of the muscles of the face and chest, and a startling appearance of the face, which is drawn gradually to one side, either the right or left. Most generally it is to the left side, and associated with a sardonic grin. The whole chest is fixed, and the body is extremely rigid. In this stage of tonic spasm, a condition of opisthotonos—a bending of the body back upon tself— may occur.

The patient presents a most horrid appearance, with the tongue protruded and swollen, and it is probable that the tongue

may be injured in this stage. This spasm is an irregular contraction of the muscles of the whole body, in which the patient is horribly distorted. The violent closing of the jaw may lacerate the tongue, and frothy, bloody saliva may be discharged from the mouth. The tonic stage of the attack lasts about half a minute. Fortunately it does not last longer, or the patient would die from the state of rigidity. Whereas, the clonic spasm may last five or ten minutes, most generally three or four minutes, when the, patient recovers from the attack of spasm and becomes quiet. This calm condition of the patient is most gratifying to the observers who suppose all is over; but in most cases it will be rapidly succeeded by a second attack. The patient may have one or two, ten, fifty, or sixty, or even more, of these attacks following in rapid succession, until she finally succumbs, worn out by the violence of the attacks, and the exhaustion attending them. If the attack has been slight, the patient may partially recover her consciousness after it has passed off, but most generally she remains in a semi-consciouscondition, complaining of headache, or seemingly conscious, she remains with more or less mental hebetude during the interval before another attack succeeds. It is a favorable occurrence, if the patient regains consciousness and rouses herself fully from the effects of the first attack. Generally, if it has been severe, she remains in a semi-conscious, semi-comatose condition during the interval to the occurrence of another attack. During the attack, no matter how long it lasts, the patient is in a state of oblivion. If she recovers after the lapse of a week, she will not be conscious of anything that transpired, will not know of anything that happened. Even though she seems rational and conscious during the intervals of the attacks, when she recovers from these convulsions, the time is a perfect blank in her existence.

Some time since, I saw a case with Drs. Guhman and Cooper, of a young woman, a primipara, who was siezed with an eclamptic attrck. She was treated very properly for five, six, or seven days, when I was called to see her, and deliver her by embryotomy. I delivered her on Saturday, and she was perfectly unconscious until the next Saturday, when she so far recovered herself, as to ask what her condition was. She was told that she had been delivered some eight days previous.

There were two weeks in her life that were an entire oblivion. For a whole week after her delivery, she was entirely uncon-

scious of the fact, had no possible remembrance of it. The attack as I said, occurs generally during labor; during the dilation of the os, or during the pressure of the head of the child upon the painfully distended perineum. If the attack commences previous to labor, it generally brings on labor prematurely. If labor has not commenced at the beginning of the attack, it is almost certainly induced, as the woman is nearly always delivered before she recovers from the puerperal eclampsia. The prognosis in these cases is exceedingly grave. As I stated, it is one of the most formidable accidents we meet in the lying-in chamber; not only frightful in its violence, but absolutely dangerous. The prognosis is very grave, concerning both mother and child.

Ramsbotham congratulated himself, that only one in three patients died of this malady, under the improved treatment in his day. It is supposed now than one in eight or ten die; still this is a formidable thing, when one in ten die. The child very often dies. It dies during the violent convulsions of the mother. They are supposed to cut off its respiration through the placenta by the disturbance of the circulation during the violent spasm of the mother—the uterus participating in the spasms. These eclamptic convulsions resemble the convulsions of childen in their appearance. The mother's life is jeopardized the child's life is seriously endangered. Each convulsion threatens to cause the death of the mother. It may be that the tonic contraction during the early manifestation of the convulsion, causes a state of rigidity of the respiratory muscles, and the woman may perish of apnœa—want of breath, Sometimes death is from an apoplectic effusion—extravasation—in the brain. The pathology of the disease is intimately associated with its etiology. It was not until after the discovery by Lever and Frerichs, that there was albumen in the urine in these cases, that it was supposed to be due to albuminuria. Braun supposed it to be caused by Bright's disease; but that was very soon proven not to be the case. Then it was supposed not to be due to Bright's disease, but to the pressure upon the ureters interfering with the free discharge of urine from the kidneys, the retention of urea in the blood, and this is doubtless true, in, part, as it is a fact that the pressure of the uterus upon the ureters does interfere with the function of the kidneys and renal vessels, rodncing hyperæmia, of the kidneys and retention of

urea in the blood. Now this is evidenced by the fact that it is nearly always primipara who have this. In eight cases out of ten it occurs in women in labor with the first child. It is with the first pregnancy that the abdomen is most tense and the pressure upon the ureters and renal vessels would be the greatest, thus showing the intimate relation between primipara and the occurrence of puerperal convulsions. But eclampsia is, doubtless the result of the peculiar blood state and the condition of the nervous system, belonging to and essentially connected with the child-bearing woman.

The pregnant woman will have an excess of waste material in her blood. The process of decay going on in her system and that of the child's, loads the blood with the excrementitious materials of her own system added to that of the child, so that she has her blood deteriorated to a very great extent during pregnancy. Such a woman has the blood loaded with an excessive amount of wasted matter, excrementitious material, then she has added to this an impoverished or watery condition of the blood. hydrohæmia, then she has added to that, hyperinosis. Now formerly it was the practice to bleed pregnant women and the necessity for this was considered proven by the appearance of the blood which always gave a buffy coat, and the buffy coat of the blood was taken as a mark of an inflammatory state of the system and this was argued to prove the necessity of blood-letting.

It is now well known to be the result of the presence of an excessive amount of fibrine from the necrobiotic processes going on in the system of the child, and that of the pregnant woman. It is the result of an excessive amount of fibrine, and a diminished amount of albumen in the blood, so that the blood state in the pregnant woman is peculiar. We have hydrohæmia, hyperinosis, excess of fibrine, leucocythæmia, excess of white blood corpuscles, diminution of the red blood corpuscles. Then we have in this condition of pregnancy an excessive excitability of the nervous system. The nervous system of the pregnant woman is in much the same condition as that of a child. It is in a state of great excitability.

She is always in a state of emotion and her nervous system is subject to jars and shocks from slight causes. In pregnancy probably, her nerve force is absolutely diminished, but it is in a state of excessive irritability because of the blood state. This

is particularly the case in primiparous patients, and as before stated, eclampsia nearly always happens in primipara. Doubtless the vicissitudes of the atmosphere has an influence on pregnant women. This connection of the atmospheric condition with puerperal convulsions, was mentioned by the elder, and confirmed by the younger Ramsbotham, and also by Barker and others. There is no doubt that eclampsia is epidemic under some particular conditions of the atmosphere.

The elder Ramsbotham says it prevails when there is thunder in the air, and is true. It does prevail when the air is surcharged with electricity. That is exactly when it would be likely to occur, as when there is an excitable condition of the nervous system, a liability to convulsive seizure would be greatest in this state of the atmosphere. Some patients measure the amount of electricity in the air almost as well, and as readily as an instrument would do; as do hundreds of neuralgic and rheumatic patients measure the amount of moisture in the atmosphere almost as certalnly as an hygrometer would do. So that we are intimately associated with our surroundings, and influenced by them. Exceedingly excitable persons, such as the pregnant woman, where the nervous system is exceedingly excitable, are liable to have an explosion on the slightest cause, and measure the amount of electricity in the atmosphere. So that you may have as shown by Barker, ten or twenty cases of puerperal convulsions occurring in a given locality in a single day, and then not have as many again during the entire year. We may readily see that in consequence of these intensified external conditions of the atmosphere, almost every pregnant woman of an excitable temperament in the city, might have puerperal convulsions. I have no doubt of its being associated with atmospheric changes. The most interesting is the Traube-Rosenstein pathology of eclampsia. These suppose that with the blood state given, together with hypertrophy of the left ventricle, present in pregnancy, we have first an increased pressure in the arterial system; this is intensified during a pain causing hyperæmia of the brain. This on account of the hydræmia causes œdema. This œdema, again, causes consecutively anæmia of the brain. The effect of this anæmia, is an eclamptic seizure.

Now the treatment; and this is the most important to you as physicians. It is of infinite importance to the well-being of the

patient. It does not concern the patient what theory you may entertain as to the etiology or pathology of the malady; that concerns your intelligence; but your treatment of it, does concern her well-being and is, therefore, of the utmost importance to the patient who is of all in the world, the most interesting. It concerns the well-being of the woman and her offspring, as both are likely to perish if you are ignorant of the manner of relieving her. And then it is just one of those occasions which are most trying to the practitioner on account of the suddenness with which it makes its appearance, and then it is unlooked for, and we are not prepared against it. It creates an amount of alarm in the lying-in chamber which nothing else can, so that if the doctor is unable to control himself, he adds to the disorder and confusion around him.

Ramsbotham congratulated himself upon the improved treatment in his day. It was supposed that the disease was an apoplectic seizure or of that nature, and that it resulted in congestion of the brain, and, therefore, the lancet was the remedy; this advanced treatment and great saving of human life was by a universal resort to the lancet, and he does so very properly. He had improved the treatment over that of Humphreys. About one patient in three or four died, about from thirty-three to twenty-five per cent. of eclamptic patients died under the advanced treatment—the use of the lancet. After the discovery by those later pathologists of the frequent connection of albuminuria and puerperal eclampsia, the connection of these were taken as evidence of the connection of puerperal convulsions and Bright's disease of the kidneys, and of course the lancet was rejected. Nobody thought of bleeding for an advanced condition of Bright's disease—an organic wasting disease. The treatment was rather to build instead of reducing the patient, therefore, the lancet was rejected; and during Cazeau's time, the lancet was everywhere laid aside. So we see the pendulum swinging too far to the opposite side.

Later again we see practitioners resorting to the use of the lancet. Some modern physicians it is true, have rejected the lancet. You constantly see such remarks from such authors as Playfair, and others; that the treatment has been greatly improved, and the mortality is greatly lessened by the non-universal resort to the lancet. Now there are so methings in the teachings of great men, that it is difficult to account for. I have

pointed out a number of such to you that seem to be without any possible logic, or logical sequences, and this is one of them. Ramsbotham and the older physicians bled greatly, and repeated the bleeding because they had no other resort. They are not to be blamed for the use of the lancet, because we in this day have other remedies that we can sometimes substitute and bring in as a part of the treatment. It does not follow that their treatment was incorrect, simply because we have other remedies at hand to assist us; and it does not follow that we are not to resort to the lancet because we have other remedies, not at all. Such a conclusion is utterly illogical. Suppose then, that we have a woman in labor, for it is during labor that it usually happens, suppose we have such a patient taken with an eclamptic seizure, contraction and other evidence of eclampsia what are we to do in the case? Now, we have several theories upon which we justify the treatment by blood-letting. The Traub-Rosenstein theory is that puerperal eclampsia was the result of urea in the blood, and albumen in the urine. Of course albumen in the urine, and urea in the blood, produced an impoverished state of the blood—produced hydræmia; and the theory was, that the blood was greatly impoverished—watery; that increased vascular tension is always present during pregnancy, and that during labor the muscular contraction increased the arterial tension and that owing to the impoverished condition of the blood, the increased arterial tension—the vascular force—we have hyperæmia of the brain. That is one of the necessary conditions attending labor. Hyperæmia of the brain produces œdema of the brain; an effusion of water into the brain tissue, and this œdema by pressure on the capillaries and blood-vessels, produces anæmia of the brain through the central portion of the brain. But the convulsions are not the result of œdema directly, or of hyperæmia, or of hydræmia, not at all, but of anæmia.

Let us suppose this theory to be correct, we will find it does not militate at all against the use of the lancet. The first thing to be done, I would urge in an ordinary case of puerperal convulsions happening during the latter stage of pregnancy, at the beginning of labor, or during the progress of labor, the first thing to be done is to have free blood-letting. It has been abused because it was the only resort. I have bled a woman for these convulsions, and if the convulsions reappeared, I was com-

pelled to bleed her again, because I had nothing else to substitute for it; there was no possibility for doing otherwise. If a patient is taken with eclamptic seizures, bleed her. Some thirty years ago I was called in consultation to see a young woman in labor with her first child, when she was taken with an eclamptic seizure. All were alarmed. The physician in attendance scarcely less than the friends. I opened a blood-vessel in each arm and bled her during the convulsions. Perhaps this is not always the best method, it is not always necessary to do so, and often it may be better to simply prevent the patient doing herself an injury during the attack. Prevent her injuring her tongue, and have some attendants to see that she does not fall off the bed. She is not likely to do so, however. She should not be held down, and no effort should be made to restrain the muscular movement, simply prevent her from injuring herself. Or in violent cases you may do as I did, immediately open a vein and bleed her abundantly, almost to syncope. Make a strong impression upon the system; young women, as a class, are most liable to these seizures, women of short stature, heavy set young women, of coarse fibre, short neck, and plethoric appearance; these are most liable to have puerperal convulsions, yet the thin, delicate, emaciated may have eclampsia during the pressure of the head upon the perineum. So then you bleed the patient freely until the lips become pale, and the pulse weak; make an impression upon the arteries and heart's action.

Well now, we bleed these patients for this reason; first, to relieve the congested condition of the brain, and to relieve the excessive action of the heart and arteries, to relieve the tension. Ordinarily we bleed such a patient very freely—from 30 to 40 ounces. Bleed her until you make an impression, and relieve the congestion of the brain. Bleed them on the Traub-Rosenstein theory to relieve the œdema of the brain. If the Traub-Rosenstein theory be correct, this is necessary, and if not, it is more so. If such a condition as Traub-Rosenstein describe exists, the lancet is absolutely necessary. The objection that these pathologists make to bleeding, is that the vessels are refilled with blood more deleterious than before the bleeding. Well we bleed the patient and relieve the brain, and the arterial tension. The Traub-Rosenstein pathologists admit that we relieve the convulsion, and that is just exactly what we want to do. Bleed

but a single time, and bleed boldly. Now we have bled the patient to relieve the congestion of the brain, to relieve the tension of the heart and arteries, to relieve the congested condition of the lungs. We have withdrawn a large quantity of blood from the system. Now we will purge the patient very freely. If she is conscious we will give her ten grains of calomel, and, ten grains of jalap—give a hydro-cathartic. But very possibly she may not be in a condition to take this, usually the patient is unconscious, therefore, we are fortunate in being able to purge her without her being conscious. And now we will give her ten grains of calomel and one grain of elaterium, make this into four doses so that we have a quarter of a grain of elaterium in each dose. We now place this on the back part of the tongue and it will readily pass into the stomach without any voluntary effort on the part of the patient. In half an hour we repeat the dose, and continue to repeat it every half hour until the patient has taken the four doses, or a whole grain of elaterium. This will produce an abundant watery discharge. But suppose the eclampsia still comes on, what are we to do? Well, the older physicians would have bled her again, because they had no other remedy. Fortunately for us, we have. Now we have bled her and purged her, but the convulsion still persist. We now use anæsthesia—chloroform. We give the patient chloroform, get her under its influence and keep her in this condition during the threatened return of the convulsions; give it as we give it in labor; give it whenever the convulsions threaten to return; do not keep the patient under its influence all the time. But possibly there comes a time when we cannot continue the chloroform, now we resort to the hypodermic injection of one-quarter, or one-third of a grain of morphine. If the patient has not been delivered, if the convulsions occur during the period of labor, deliver her if possible. If the convulsions occur during, or before labor, they will probably disappear after the delivery. If you can deliver her do so. If it is a difficult labor, introduce the forceps and deliver her.

In the case that I saw with Drs. Guhman and Cooper, the woman had been in labor several days, and the child was undoubtedly dead. There was a suppression of urine and the woman was in a comatose condition. The patient must necessarily die unless something was done for her, and the only thing that we

could possibly hope would relieve her was to deliver her. We accordingly did so by embryotomy. If the patient be in the later stage of pregnancy and the convulsions occur, bring on premature labor—empty the uterus. I have met with but one case of puerperal eclampsia occurring after labor. I remember a case of a lovely young woman whom I delivered of her first child, the labor progressed as usual and some hours afterwards the patient fell asleep and awoke with an eclamptic attack. I remember she had lost very little blood during the labor. I let this patient die, but I am satisfied if I had bled her 30, 40, or 50 ounces, she would not have died. So then in these cases, bleed your patient, purge her, give chloroform, and if the attack still persists give hypodermic injections of morphine, and relieve the uterus by delivering the woman.

Proceedings of Medical Societies.

Article XXVII.

ST. LOUIS MEDICAL SOCIETY.

Taken by the Journal's Stenographic Reporter.

Saturday, Dec. 3rd., 1881.

Nasal Calculi.

Dr. Rumbold.—Mr. President; on last Saturday evening, in my remarks on the formation of cretaceous masses in the nasal cavities, I stated that their growth was comparatively rapid. I had, at the time, in mind the history of a patient that first came under my observation in 1873. Shortly after this first visit, I removed a piece of bone which proved to be a part of the right antrum of Highmore. I here present it it to the Society. In January 1875, I removed a mass of cretaceous matter from the same locality. It is in this box which I will pass around to the members. In July 1876, I removed another cretaceous mass from the same place, which is in another box. It is seen that they are both about the same size and shape. I stated last Saturday that the masses would weigh nearly two ounces. I now see that I have written down their weight as four ounces. I find that I have still other masses of this cretaceous matter taken from the same patient, all of which goes to prove a very rapid growth. This was removed in December 1876.

Dr. Pollak.—How did you get them out?

Dr. Rumbold.—Through the nostril. The septum of the nose was destroyed, the turbinated bone was partially destroyed, also, so that they could be grasped by an instrument quite readily.

Dr. Pollak.—Was it a syphilitic case?

Dr. Rumbold.—Yes sir!

Dr. Porter.—I have, not in my posseasion, but within my

knowledge, a most interesting specimen, a foreign body which was removed from the nose of a gentleman of this city. He had chronic discharge from the right nostril, and had been well treated by others, and when I examined him I could not see why he had not gotten well; but on watching the case a little farther, I found that it did not answer to the usual methods of treatment. There was a great deal of irritability on the right side, and in the right nostril. To make a long story short, one day he discharged from the antrum, there is no doubt now of the locality, a little mass which was found to be an embryonic tooth that had been pushed into the antrum, and had doubtless remained there many years. This gentleman said that he had this discharge since boyhood, and he is now 36 or 37. The discharge of this foreign body completely relieved him. It was a unique case in my experience, and to me a very interesting one.

Asthma from Nasal Polypi.

Dr. Mulhall.—I have an interesting case to present, not so interesting from its objective signs, as it is for the relationship between these signs. The case is one of asthma, dependent, as I think, on nasal disease, gelatinoid polypi. I have not touched the man's nose yet, so those who wish to examine him, may see the case in its entirety. The history of the case shortly is this: The man is 43 years old and married, has never had any serious illness, and has not been more susceptible to cold than other people. In December 1880, he noticed a watery discharge from both nostrils, and nasal respiration became gradually impeded. Two weeks afterwards, immediately after lying down one night, he felt his throat obstructed and began to cough and have labored breathing, expectorating small quantities of foamy mucus. He arose and getting into the asthmatic position, had some relief. This state of affairs continued for a month when he sought treatment. He informed the practitioner that his nose was stopped up. This gentleman ordered him a snuff and some medicine internally, neither of which gave him any relief. Indeed, though he consulted another practitioner, and took many medicines, he experienced no relief whatsoever from his asthma until May. On questioning him, he now is sure that before relief came to him with the summer season, the nasal respiration became freer, his chest symptoms vanished, and in three weeks he was perfectly free from trouble, and remained so until August, having

meanwhile regained 40 pounds in weight that he had lost. In August his nose began to discharge watery mucus, in three weeks his nose was again almost occluded, and his asthma reappeared. Since then he has had asthmatic seizures by night, as well as by day, although he has been the patient of an eminent practitioner who prescribed many kinds of treatment for him, but as formerly, without the slighest alleviation of his symptoms. At any moment of the day or night that he assumes the recumbent posture, he at once has his suffocative signs. The seizure he knows is coming by the dryness of the tongue and fauces, and a sense of constriction at his larynx. For the last three weeks he has, at no time been able to take a deep breath on account of the pain it gives him about the false ribs and upper abdominal region, and for the same time he has suffered with headache day and night, in the frontal and occipital regions, being worse in the orbital region. All his symptoms are intensified at night. He is never able to pass his water during an attack, and it takes him fifteen minutes to pass it after an attack. Indeed, any time during the last three weeks, he has not been able to pass his urine in less than fifteen minutes. I thought this would be a very interesting case, because, in searching up the literature on the subject I found that asthma with nasal disease as the reflex cause, has attracted very little attention. In the United States there exist but two papers upon the subject; one that was read at the Missouri Medical Association meeting this year; it appears in the report of the transactions for 1881. Dr. Todd of St. Louis, read his paper with the account of a case, in which asthma was caused by a large growth in the retro-nasal portion of the nose, and he cured the asthma by removing the growth. Dr. Wm. Porter of St. Louis, has a paper on the subject in the *N. Y. Medical Record* for November 1879, with details of a case in which a cure of asthma followed the removal of nasal polypi. Fraenkel read a paper before the Berlin Medical Society, published in the *Berliner Klinische Wochenschrift*, in January 1881, in which he says that up to his time, no regular paper had been written upon this subject. It is an extensive paper in which cases are cited, and in it he says that he was the first to draw attention to the connection between nasal diseases and asthma, in 1871.

I propose to remove the growths in this case, and then to present the man again to the Society.

Dr. Porter.—Asthma is not a disease, it is rather a symptom of disease. It is a bronchial spasm and may be due to local change in the tubes or to reflex irritation. Possibly of the latter class there is no kind of reflex irritation that produces more persistent, or more distressing asthma than irritation along the upper respiratory tract.

I do not like to cite cases that I have published elsewhere, but as they have been mentioned by the doctor, I will refer to some of them. The cases were published in the *New York Medical Record* two years ago. The first was that of a well-built, middle-aged man without any vices, and without hereditary taint so far as I could learn, who had persistent asthma. His paroxysms were very much worse at night, a little worse in cold weather. Upon examination I discovered that the nasal cavity was crammed with small polypi. The mucous track was very sensitive, so that the inhalation of irritating substances, immediately caused asthma. The introduction of a small cotton-covered probe, touching these polypi caused a severe paroxysm; and as at that time, there had been no recorded cases, except the case which formed the basis of the paper published in Europe, I was unwilling to say that the polypi were the cause of the asthma, but my experience with this case taught me so. Of course one of the first things to do, aside from the general treatment of the case—I did attempt to treat it by the treatment usual in asthma—was to remove the polypi. I tried to remove them with chromic acid, and the introduction of iron, but that gave rise to so much pain and irritation, that I resorted to the use of the ordinary forceps and so removed them. I did not cauterize the base, and here comes an interesting point; as soon as the polypi were removed the asthma disappeared entirely, and for probably three months, there was no return. They reappearded, and with them the asthma returned. Willing to test the case further, I removed them again, but did not cauterize the base. The polypi reappeared and the asthma returned; the matter was now fully tested and the next time the neoplasms returned I put a strong solution of chromic acid all over the mucous membrane upon which they grew. There was no return of either the polypi or asthma. Although the bronchial symptoms were fairly well marked, such symptoms as we generally find in a case of somewhat recent asthma, they disappeared directly when the polypi were removed. I am told that ther

has been a return of asthma in this case, probably because of further developement of polypi.

In an other case there was a very irritable tonsil, and though not suspecting than the tonsil had much to do with the asthma, I suggested its removal. In cutting it off my guillotine struck something hard and I found a small calculus embedded that had caused the obstruction to the knife; when it was removed the symptoms disappeared. Still a third case was one in which there was an irritation from the ovary. I saw the lady in consultation with a practitioner in the city, who already suspected the exciting cause; when that was relieved, and the irritability was removed, the lady got well. I have since then met with another case in which the symptoms all disappeared.

There is in all these cases one very important point to be remembered, I don't mean to say in these cases only, for they are almost too rare to form the basis for a conclusion, but in all cases of asthma, from reflex irritation, relief may generally be obtained by the removal of that irritating cause; yet not always, because when of long continuance, on account of local changes, the irritability of the mucous membrane will continue after the exciting cause has been removed. I think Dr. Mulhall will find when these polypi are removed, that there will be great relief, but it may not be complete.

DR. RUMBOLD.—In 1869 I reported to this Society the removal of a number of nasal polypi by injections of astringent preparations of iron, such as the perchlor. and persulph. of iron by means of a hypodermic syringe. I gave the history also of a patient whose asthma, of two years standing, had been relieved by the removal of some ten or twelve nasal polypi by the hypodermic syringe. His relief lasted for several months. I stated, at the time, that the removal of the polypi gave him some relief from the irritation arising from the chronic catarrhal condition of the mucous membrane of his nasal passages and that the asthma was due to this chronic inflammation and not to the presence of the nasal polypi. All that these growths had to do with his asthma was that they gave rise to a greater than usual irritation, and that this irritation caused the asthma, and that I thought the asthma would return if the chronic inflammation was not reduced to some extent.

We have patients afflicted with asthma who have not a single

polypus, but we *cannot* have a single case with nasal polypi unless chronic nasal catarrh has been existing *for a long time.*

In 1879, Dr. Fischel read a paper on "the treatment of asthma by the Waldenberg apparatus;" at that time I stated that I had relieved attacks of asthma by the removal of nasal polypi; I also stated at that time, that I believed that attacks of asthma were due to an irritation arising from chronic nasal inflammation. This is my present belief which I have stated in my work on "The Hygiene and Treatment of Catarrh," pp. 404-411.

Dr. Fischel.—I don't know anything about the case brought here this evening, but I am inclined to agree with Dr. Rumbold in his views that nasal polypi do not often bring on attacks of asthma. I have in mind now one case, and I think possibly that it is the case which Dr. Porter has referred to this evening. The gentleman had been under my care for a long time, and at tmes I thought that he was being materially benefitted with Waldenberg's treatmemt. He said Dr. Porter had examined his nose, and found, as I found, that he had polypi. Dr. Porter removed the polypi. But I am quite sure the patient was not cured of the asthma. I don't think I have ever seen a case of asthma where there was not nasal catarrh connected with it; and I think that the history—the etiology of the trouble bear me out in that. It is possible that the nasal polypi are the result of catarrh, and not that asthma, is the consequence of the polypi. Of course the polypi by obstructing the nose would increase the trouble, and they should be removed; but I am inclined to believe that their removal will not cure the asthma.

Dr. Mulhall.—I will say there is no history of asthma, or nervous trouble, and I took his history very carefully with regard to nasal catarrh, and he states very positively that he had no discharge or any symptoms of nasal irritation before the time stated. Asthma is of course only a symptom; I think all the authorities that I have read, state that in the majority of cases, the cause of the asthmatic disease is within the chest; and from what I have seen of asthma, it seems to me that in the majority of cases, the primary disease is in the chest. As regards his being cured by the removal of the polypi, it will be remembered that I stated in the history, that he was cured by the warm weather, because the warm weather removed the polypi, the watery secretion was

dried up, and they shrivelled up so that the nose became perfectly free, and he gained in three months forty pounds which he had lost. He did not have the least symptom of irritation of any kind during the continuance of the warm weather. I have examined his chest very carefully, he has physical signs of emphysema; he has slight bubbling râles in the larger bronchi in the lower part of the chest; anteriorly above, there are no morbid chest sounds, except prolonged respiration. I think the history of this case without physical investigation, would at once have told one that the asthma was connected with the nose. He has a watery discharge from the nose, and in the course of two weeks, the nose is almost completely occluded, and then the asthmatic symptoms come on. Later his nose becomes free, and his asthma disappears. In August the watery discharge from the nose again makes its appearance, the nose fills up and the spmptoms of asthma return. It seems to me that this is surely a case of asthma caused entirely by nasal polypi.

DR. RUMBOLD.—The fact that Dr. Mulhall's patient was better during the summer months, at the time in which catarrhal inflammations would be improved, and the polypi be shrunken, is evidence that both the polypi and asthma are due to the catarrh.

DR. MULHALL.—I think an examination will show that he has not got catarrh now.

DR. RUMBOLD.—I am positive that he has nasal catarrh now, the presence of the polypi are the proof of it; the polypi are the result of long continued catarrhal inflammation.

DR. HUGHES.—It doesn't occur to me that in seeking to explain the possible modus operandi of reflex action from the nasal cavity upon the diaphragm, one should circumscribe the irritation exclusively to the nasal pedicle of the polypus. Now in those instances where the polypi are the sources of irritation, there is more or less diffusion throughout the whole nasal cavity. While we may not agree in particular cases as to the fact that asthma is produced in this way, I think there can be no doubt that we have reflex asthma from an irritation of the nasal cavity. I think that Ramey's explanation of the contiguity of the origin of the cranial nerves in the floor of the fourth ventricle and medulla, will explain the possibility of nasal reflex irritation, as in the physiological act of sneezing, quite satisfactorily. I have

seen cases of asthma without any irritation of this kind in the nose; and I have seen cases of asthma that recovered in spite of the irritation of the polypi in the nasal cavity.

Dr. A. Green.—I agree with Dr. Porter, that asthma, is in a great many instances, only a symptom. By "asthma," we usually mean periodical attacks of dyspnœa, with perfectly free intervals, attacking individuals not affected with any pulmonary or heart disease, of which it is so often a symptom. As science progresses, we may probably find what we now consider a neurosis of the vagus nerve, without, any pathological anatomy, is really due to some anatomical lesion, and then asthma will cease to be an idiopathic disease, and be only a symptomatic one altogether, but not so in the present state of science.

By catarrh we mean a superficial inflammation of the mucous membrane, with hypersecretion, as a result of the hyperæmia, which is either active or passive, a fluxion or stasis. The mucous membrane and its glands do not perform their function, they do not secrete at all for a while, or, which is usually the case, they secrete too much, and the secretion itself is not a physiological, but a pathological one. It may be caused by a cold or not. If a patient says: I have no cold, it does not follow that he has no catarrh; because he may have no cold, and still have a catarrh.

The glossopharyngeus, spinal accessory and the pharyngeal branches of the vagus, supply the superior and middle constrictors, and the mucous membrane of the pharynx, even the superior laryngeal supplies the inferior constrictor. How far is it then from the posterior nares to the mucous membrane of the pharynx? And does not inflammation extend by continuation of the same tissue? We should therefore not consider it strange when nasal polypi and catarrhal inflammation of the nose, under certain conditions, give rise to asthma, which is considered to be a neurosis of the vagus nerve.

Dr. Hurt.—I have been in the habit of distinguishing two classes of asthmatic trouble; the dry asthma, in which the mucous membrane, as far as it can be seen, and all the symptoms, indicate a deficiency of secretion; and the moist asthma, in which there is an excessive secretion of mucous. To say that asthma does not originate in a catarrhal affection, would be contrary to my observation. The disease called hay fever, or hay asthma is almost invariably attended with a catarrhal condition of the nasal

passages; and I have seen some as severe asthmatic symptoms in hay fever as in any other form of asthmatic trouble. My opinion is that, whether it be a simple neurosis, or whether it originates in a catarrhal condition of the mucous lining of the respiratory mucous membrane, there is always more or less blood stasis. Even in the case of a simple nervous asthma, the condition of the mucous membrane would perhaps be analogous to the condition of the skin in some other diseases that are known to be due to irritation of the terminal branches of certain nerves, as herpes, for example.

DR. JOHNSTON.—Do you think that polypi produce asthma?

DR. HURT.—I should think they might; at any rate, the same cause that produces the polypus is competent to produce an asthma, irritating and congesting the mucous membrane; and I believe it is possible for obstruction of the nasal passages in some very susceptible persons, to cause asthma; but that would not be the case in all individuals. Many persons have nasal polypi who do not have asthma.

SATURDAY, Dec. 10, 1881.

Laceration of the Os Uteri in Labor.

DR. ROWLAND.—I will report a case which may be of some interest. About four weeks ago I delivered a delicate lady of rather small stature, and weighing less than a hundred pounds, of a comparatively large male child—it weighed between 9 and 10 pounds. She had enjoyed pretty good health during gestation, better than previously. The labor was protracted; she was in labor some fifteen hours, the expulsive pains being pretty hard. The presentation was natural, the first position, vertex presentation. Nothing unusual occurred in the case until just as the child's head was born, or rather, just before it was born the woman complained of more than usual pain. Such was the distension of the soft parts, that I very much feared a laceration of the perineum. After the birth of the child I introduced my hand to find out what was going on in the womb; and I found a double laceration on the right side to such an extent that I feared it had been torn into the peritoneum. The patient was pretty much prostrated by shock, and after the immediate alarming symptoms passed away, she still complained of more than ordi-

nary pain for a primipara. She continued to suffer more than usual pain for two or three days. Since that time she has had an unusual amount of soreness in the region of the womb, but there has been only little more discharge than usual. I examined her to-day, and find that the case seems to be doing admirably, and I hope that there may be no bad consequences. I am inclined to think that this accident occurs much more frequently than is generally supposed by the profession, judging by a number of cases in gynecology where I have found indications of laceration.

Dr. Pollak.—Was there much hemorrhage?

Dr. Rowland.—Not a great deal; still more than there would have been otherwise. The hemorrhage continued for several days. The laceration seemed to be an inch and a half long, and the lips of the wound were considerably everted.

Dr. Rumbold.—I think that Dr. Rowland would add greatly to the value of his observations if he would inform the members of the Society, say in six months from this time, of the result of the healing of this laceration.

Dr. Hurt.—From the case as reported by Dr. Rowland we would infer that there was tardiness in the dilatation of the os uteri. It seems that at the time the laceration took place, when the patient noticed that something unusual was taking place, the head was distending the perineum. Usually when this occurs the os uteri is fully dilated, and in fact, at that stage of labor, the head—the largest part of the fœtus—is not engaged in the os uteri. It would be interesting to know, if the fact could be ascertained, whether the laceration commenced in the os uteri, or in the vagina. In a labor having advanced sufficiently to distend the perineum, the head has usually passed out of the cervix, according to my conception of what takes place in natural labor.

Dr. Johnston.—I supposed that the laceration of the cervix took place before the head had passed down in the soft parts. The laceration usually takes place there first, but we cannot discover it until the child is born.

Rr. Rowland.—I am not able to say, of course, when the laceration occurred. The only indication I had of it was that the woman complained of considerably more pain than usual a

short time before the birth of the child's head. Perhaps I should have stated the dilatation of the os was about as usual, except that it was rather slow in dilating; and as the pains were rather feeble, and the labor protracted, I gave her a very small amount of fluid extract of ergot; but not a sufficient amount to produce any unusual pains. Labor progressed slowly and very steadily. I am inclined to think that there will be very little to mark the place of laceration in six or twelve months, judging from its size at the present time. I might state that I have taken more than ordinary pains in having the vagina kept clean by using carbolized injections twice a day. I have kept her very quiet, and in a horizontal position.

DR. MAUGHS.—I cordially agree with Dr. Johnston in what he has stated in regard to the operation for laceration of the cervix;* the question seems to be "who killed Cock Robin?" I claim to have killed him in a paper that I read before this Society, and published in its proceedings in 1868. In this paper I denounced the universal resort to this surgical procedure, the bi-lateral operation in dysmenorrhœa. Some gentlemen boasted of having performed it 300 or 400 times, and I predicted that in ten years the man would not be found who would boast of having performed it anything like that number of times in a lifetime. I stated at that time, that the bi-lateral incision was a valuable addition to uterine surgery; I stated that there were a few cases in which it was really a most valuable procedure, but that it was not even generally the best procedure in dysmenorrhœa; I stated that there were a few rare cases of indurated, conical pointed, inter-vaginal cervices in which the bi-lateral incision would be the procedure, but that they were rare. I have performed it a few times, a very few. The fault is not with the operation, it is in the montebankism, the desire for notoriety which has become so marked in the American people. As soon as the procedure was published, every one rushed forward with a paper, and published as large a number of cases as possible. It was stated in this society by one of the members, that among the earliest of these operations was its performance by me upon his wife for dysmenorrhœa, and she was greatly relieved. I say it is valuable in a few cases. The operation of Emmet is having its day. It is valuable in a few cases, also. I have performed it, but we

*See the number of this JOURNAL for July, 1881.

are not justified in performing it on every case of slight laceration of the intra vaginal cervix. In almost every labor, especially in primipara, there is more or less fissure of the os uteri. It is almost a necessity in primipara, and it is stated by Klopp that it takes place in almost every labor, however natural. In a few months it is scarcely discernible, but sometimes it remains raw, the granulating surfaces are closed in a manner, but not cured; then it is necessary to denude the edges and close the wound. I have seen two or three cases in which this would have been the best procedure, and I have seen a case in which it was the only advisable procedure. This was a case sent to me from a distance, a case of procidentia, which was the result of hypertrophy of the intra-vaginal cervix from a laceration, a bi-lateral laceration of either side. It was split up to the vaginal junction. This lady was past the menopause, it having happened 14 years before at the birth of her last child, and remained all that time; the raw granulating surfaces becoming enormously hypertrophied and producing procidentia. There were only two methods of procedure in this case. The one was the operation of Emmet; the other was to amputate this enormous hypertrophied cervix. I chose the former, though the other was probably equally valuable. The operation is one of the most simple in minor surgery. One operator boasted of having lacerated 450 cervices and, therefore, he created a large field for operation. Doubtless Dr. Schenck is sewing up some of these cervices now. Whenever I get a case of a badly lacerated cervix I am in the habit of saying to the patient: "You have been a patient of Dr. Pallen." It is a very simple operation to sew up these lacerations, a few strokes of the scalpel, and a few wire sutures is usually all that is required. I said in 1868 that in ten years there would be no man who would boast of having performed Emmet's operation 100, 200 or 300 times. But still it will always be a justifiable operation in certain cases, although it never can become one of universal application.

I have found those cases that Emmet speaks of, where the laceration leaves a small cicatrix; but I don't believe it causes reflex irritation. Emmet is not gospel with me. There is no doubt that Emmet has accomplished much in his profession; but his doctrines must be weighed in the balance and a good many of them will be found wanting. The laceration of the cervix might happen at almost any point if there is an obstruction at

the brim of the pelvis, at the superior strait, or if there is an obstruction by a malformation of the cavity of the pelvis, a narrowing of the cavity in the conjugate diameter. The head generally passes through the mouth of the womb and the superior strait at the same time, if the superior strait is of full size or larger than usual; but it not unfrequedtly happens that the os continues to cover the head of the child until it reaches the perineum. I have seen the head of the child in the inferior strait still covered by the excessively attenuated anterior lip of the os. There may be a laceration in the superior strait, or it may pass into the inferior strait and be lacerated there. The point of laceration would depend very much upon the undilatability of the os.

DR. BERNAYS.—I was glad to hear Dr. Maughs put himself on record in the manner he has done. I think his judgment in regard to the value of Emmet's operation is correct in every respect. The operation is an exceedingly simple one. I have no doubt that the operation is beneficial in some cases, but they are very rare. Any woman that has ever given birth to a child at full term may have a cicatrix. Of course, these cicatrices are of various sizes, and of different depths and localities, and if anyone chooses to sew up every one of these little rents he can find plenty of cases for operation. But there is another class of cases where there is a sort of fissure, which is comparable in every way to fissure in ano, or fissure in the urethra; and these cases must be operated upon, because they give rise to serious symptoms, presenting indications for the removal of the diseased tissue. I have only performed this operation three times in quite a long time; and the reason probably is that I have grown less zealous than I formerly was. I used to perform it frequently; I remember two years ago I reported 17 cases in which I had performed Emmet's operation. Since then, although my practice has increased, I have performed the operation only three times. One case is of some interest and I will relate it to the Society; it shows that this operation can be performed upon a woman who is three months pregnant, without producing abortion. The way I came to find this out is rather singular. A physician brought his wife to me and told me that she had a rent extending almost up to the insertion of the womb into the vagina; and that she suffered extremely from vomiting and tooth-ache, and with reflex spasm from this fissure. Upon exam-

ining her we found the womb enlarged to about the size of a man's fist; it was very soft. We also found a large rent nearly three-quarters of an inch long in the left side of the womb. The os was much hardened and the vaginal portion had callous edges. It was a typical case for Emmet's operation. I asked the husband if his wife was not pregnant, as the womb was enlarged; but he said she was not, as he had introduced a sound within the last two weeks. I proceeded to operate. My operation is different from Emmet's operation as he describes it. I make two clean surfaces exactly coming together in a point—uniting as a triangle. I then put in three or four silk sutures, and it is done. I think this makes the neatest operation. In this case it healed up very kindly; there was no trouble at all. In another case—I don't know that this is a good place to report professional mistakes either—but in another case where I performed the operation on a pregnant woman an abortion resulted. I would like to ask Dr. Maughs to give his opinion as to the reason why so few physicians perform this operation in the United States?

Dr. Maughs.—I can show in a minute how the operation is performed by a diagram. It is the most simple thing in the world. The doctor asks me why so few physicians perform this operation. It is because they have no confidence in themselves when it comes to a surgical procedure. Some men have practiced medicine all their lives, and yet have never applied the forceps. There are thousands of practitioners who are afraid of anything connected with surgery. I know an excellent practitioner of this city, a man who has practiced for years; yet he has never passed a male catheter, and would not attempt to pass a female catheter. There are more men in the profession who shrink from the simplest surgical operation, than one would suppose. Nothing is easier than the application of the forceps in the second stage of labor, when the head has rotated occiput forward in the inferior strait; and yet there are some who would be afraid to attempt to apply them, and would let the woman suffer twenty-four hours without attempting to put it on; there is perhaps an improvement in the performance of this operation that may save some trouble. I will illustrate it here: Say this is the laceration of the os, that is the intra-vaginal cervix, the uterus is above. Now the first procedure is to take a hollow needle and pass a silver wire through it, then pass it through in this way, bring it out

here, pull it down and tie the ends together, and you have a permanent hold. The lacerated surfaces are brought into exact position. We just pass the ligatures around here commencing at the laceration, the wires are then brought together.

Maternity at an Advanced Age.

DR. HURT.—It seems to me that the opposition which has been expressed by some is not against the operation, since it is admitted that there are cases in which it ought to be performed; therefore the opposition is not against the operation, it is against the abuse of it. Well I suppose we could take the same position against any operation. I don't want to cut short the discussion of this matter, but I wanted to make a statement here which came to my knowledge in regard to the age at which it appears a gentleman contends that his mother had reached at the time of his birth. A gentleman was examined in the town of Cameron in this state, for insurance; and he states that he is 39 years of age, and gives his mother's age at 103, and still living. The application was referred to me and I took exception to the fact that the statements made his mother 64 years of age st the time of his birth, and I wrote back calling his attention to this fact, and in reply the applicant insists on the original statement, and says that his mother lives with an older son in Indiana, and is now in fair health for a person of her age. I was acquainted with a family in Kentucky, some 30 years ago in which there was a maiden lady who when 53 years of age married, and in the course of twelve months she gave birth to a healthy living son. A lady, a mid-wife in this city, informed me the other day that she was 57 years old when she gave birth to her last child.

DR. BERNAYS.—In this connection it may be well to bear in mind that the fact that menstruation stops about the age of 45 would have no bearing on this subject, because we know that ovulation is independent of menstruation.

DR. JOHNSTON.—I would like to enquire when ovulation ceases. Lawson Tait says that ovulation and menstruation are independant of each other.

DR. HURT.—I don't know at what age in female life ovulation ceases, but I believe from recent reports of observations by scientific investigators on the subject, it is conceded that ovula-

tion commences very early; in fact, I believe it is maintained that it commences in intra-uterine life.

Dr. Maughs.—There are very few well authenticated cases of women over 60 years of age having children; and while it is not at all impossible, it is improbable that a woman will have a child after she is 60 years of age, after she has ceased to have the epi-phenomenon of menstruation. Most women between the ages of 43 and 48 years cease to menstruate, that is, they no longer have a colored discharge because they cease to ovulate, and the ovaries fall into a state of senile atrophy. There is no longer vitality enough to develope Graafian follicles, and there is no discharge of ova; and it is necessary to have an ovum in order to have impregnation. It is not absolutely necessary to have the epi-phenomenon which is usually present, however. It is not possible for a woman to conceive who does not ovulate. Dr. Hurt mentioned the fact that ova are present in the female fœtus; the ova are an essential part of the ovary. The ovaries are not glands. They do not secrete ova at all. Changes are constantly taking place in the ovaries and uterus of the female fœtus, and the ova are undergoing changes preparatory to their fitness for the development and reprodution of the species. But it is not ovulation that occurs in the fœtus in utero.

Dr. Dudley.—I can mention a case somewhat analogous to the case mentioned by Dr. Hurt. I remember very distinctly that in my boyhood a lady who lived very near to us, and who had raised a large family, gave birth to a child when she was 52 years old. I paid but little attention to the matter at the time, except that there was considerable talk about it in the neighborhood that a lady of such an advanced age, who had not had any children for a number of years should give birth to a child. It was a very delicate male child, and lived perhaps a year or a year and a half. The lady was in very good physical condition, and perhaps this had something to do with this case. She was a very large, plethoric woman; a woman of full habit. Perhaps the menopause may have been deferred later than usual in her case.

SATURDAY, Dec. 17th, 1881.

Embolism of the Central Artery of the Retina. By Wm. Dickinson, M. D.

The subjects Embolism and Thrombosis, though of recent recognition, constitute one of the most interesting and important chapters of medical science. Magendie, Cruveilhier, Gaspard and others achieved much for patholgy when they ascertained that the injection into the blood current of animals, of starch, quicksilver and various other substances produced fatal inflammations. The knowledge of these results, perchance, by analogy, foreshadowed to the keen mental vision of Virchow, the probability that foreign bodies, differing in kind, in the circulating fluids of man were capable of producing similar pernicious results. In any event, he published in 1846 his observation upon the effects of the detachment of Thrombi in the veins, and suggested the probabilities that the same process might take place in the arteries. The experience and added observations of a single year confirmed that, which was even then more than a hypothesis, and in 1847 he was the first to enunciate the theory that detachment of fragments from the valves of the heart may be carried by the blood to remote parts, e. g. the brain, lungs, kidneys, spleen, etc., and become impacted in a distant artery.

Kirkes, Tufnell and others five years later, confirmed these same observations, though to the former in England is generally awarded the honor of the entire discovery. Virchow seems to have been the first to determine the true pathological cause of many necrotic conditions occurring mysteriously in different organs, and refer them to emboli, and to have originated this term in description thereof. Prof. Graefe was the first to announce about twenty-five years since, the discovery of embolism in the central artery of the retina. The instances in which this condition has been found are comparatively rare; probably not more than *fifty* cases, by all observers have to this date, been reported. Among these was a most interesting case occurring in the practice of Dr. Williams of this city, and by him reported to this Society one year since. In a practice, general and special of more than thirty years, not a *single* case had *then* occurred to me.

But in illustration of the trite saying, "it never rains but it pours," four cases of this affection since October 27th of the present year have come within my own practice. A narrative of which I shall briefly give in the sequel. I beg at first to present a few cases which constitute a part of the literature on this subject, as they represent typical cases and the usual symptoms.

"Dr. Sämisch narrates the case of a man of 52 years of age, who, upon waking in the morning two days before presentation, discovered he could not with the right eye perceive the lower part of any object. He connected his ailment with a "gum-boil" that had formed about a right upper molar tooth ten days before.

With the ophthalmoscope the retina presented a milky-whitish color, through which the choroid was dimly visible. The upper portions of the optic disc and vessels were normal; but the distal portions of the descending arterial branch were visible as a thin white cord, seen with difficulty in the turbid retina. No exciting cause could be assigned. No improvement in vision observed during the ensuing two months.

Dr. Hirschman records the case of a nobleman of 55 years of age, who during the preceding seven years had suffered from repeated attacks of articular rheumatism and his heart by auscultation furnished a systolic murmur. Loss of vision with his right eye had occurred suddenly six months previously while in the act of stooping, which was attended by a sensation as of fire in the eye.

The ophthalmoscope detected but slight changes in the optic disc or retina; but the ascending branch of the central artery was obstructed on the the disc, and empty or nearly so beyond the point of obstruction.

O. Just reports the case of a man of 36 years of age, who had often suffered from shortness of breath and palpitation. Without obvious cause on a certain occasion he suddenly perceived dark wheels before his right eye, followed in five minutes by total blindness. Three days later the optic disc presented a blueish white appearance; central vessels resembled delicate threads. At the macula lutea there is a smoky cloudiness. Left eye normal; heart a little enlarged; in the aorta there is a slight diastolic murmur. Ten days later he had regained some perception of sight. Under the use of Pot. Iod., in ten days the patient could distinguish movements of the hand in the outer

part of the field of vision, and in fourteen days large objects situated in the line of the optie axis; eight weeks after first examination he could count fingers. But a still later report states all perception of light was lost, probably from atrophy of the retina."

In respect to the beneficial results of treatment, Schneller relates a case in which vision was almost perfeetly restored.

The existence of embolism of the central artery has after death been demonstrated in probably less than a dozen cases. The first demonstration was made by Prof. Schweigger, of an eye that first came under the observation of Prof. Graafe. The patient was then suffering from stenosis of the aortic valves, probably from endocarditis, from which disease he died about one year subsequently. The eye being removed and examined after death, the central artery of the eye just before its entrance upon the optic disc was found to be completely occluded by an embolus which had forced its way up to this point, but here in the lamina cribrosa, where no room was to be gained, it remained fast.

At the time of original observation, vision was lost in the affected eye. "The refracting media were clear, optic nerve quite white, but not opaque as in atrophy, but normally translucent. All the vascular trunks upon the optic disc were greatly contracted. The principal arteries upon the retina appeared like delicate lines, and their branches were correspondingly small. The veins everywhere were thinner than normal but larger near the equator." A few days later in the veins irregular impulses towards the papilla were observed. Later the retina in the region of the macula lutea became opaque. A grey, white infiltration appeared which extended to the temporal margin of the optic disc and shaded off about its periphery imperceptibly into healthy tissue. "The position of the fovea centralis was occupied by a cherry red spot, about one-quarter of the size of the optic disc. The color of the spot was so intense as to suggest at once the suspicion of a hemorrhage, but which was due to the contrast of color with the infiltration. In the course of two or three weeks the infiltration disappeared, and with its disappearance the intense red color of the macula lutea passed imperceptibly into a light brown color. There was, and continued to be, only the slightest perception of light. Atrophy of the optic nerve gradually supervened."

Sichel, fils, also demonstrated the existence of an embolus in the central artery, one eighth of an inch from the sclerotic entrance of the optic nerve. In all cases the retina soon loses its transparency, a greyish cloud enshrouds the disc's immediate neighborhood; it may extend and also surround the macula lutea. This is due to œdema, and may in a short time disappear.

The cases occurring within my own practice are as follows viz:

I. Mrs. M., Sparta Ills., 35 years of age, married but has had no children, consulted me Dec. 7. Three weeks prior to this date she experienced the sensation of a foreign body in the left eye, but her friends upon examination failed to detect any. This continued for a day, and upon its appearance she perceived a dark spot apparently situated near the external canthus. Attempts on her part to scrutinize this, caused it to remove in the same direction in which the eye was moved, and thus ever to elude observation. The spot seemed of the size of a dime, the centre of which was of a dark green, almost black color, surrounded by a greenish halo. Slight pain was experienced at the time of invasion, but none since. She had suffered no blow upon the eye or head, or any form of violence to which its occurrence could be referred, nor did it occur at a catamenial period, which function was regularly maintained. Vision at first suddenly and seriously impaired continued to deteriorate for ten days when it became extinct. This has since gradually improved and she can now discern letters two inches in length at four feet; but the black letters seen imprinted upon paper of light green color; she can see more distinctly after a period of continued effort.

Ophthalmoscopic signs: Divisions of the central artery on the disc and more remote are almost entirely obliterated. Veins present, but thinner than normal. Vitreous body hazy, which rendered it impossible to discern the macula lutea, but extensive greyish infiltration existed between its site and the optic disc. Prognosis in general, unfavorable; but the improvement of vision already experienced, was an indication of favorable omen. Ordered exhibition of Pot. Iod., and Hydg. Prot. Iod., alternately each week.

II. Miss. W., a lady of 25 years, consulted me first, Oct. 31st. For ten or twelve years she has suffered much pain in the righ

eye, right side of face and in right shoulder, but vision remained unimpaired. About six weeks since, in the evening after a day of unusual employment and consequent fatigue, exposure part of the day to a drizzling rain, and some use of the eyes in reading, the *right* eye felt as though it had received a slight blow. This was accompanied by a little pain, and all objects instantly seemed enveloped in smoke, and were obscurely seen. At about the same time, she had an abscess in external meatus of right ear, and three others subsequently. She thinks vision has improved a little since. My record states; now vision is very much impaired, can only discern No. 100 of Jæger and that peripherally, i. e. letters two inches in length, at thirty inches; vision to her appears obscured by an opaque elliptical disc, greater diameter horizontal, twelve inches by eight, and situated apparently about eighteen inches in front of the eye.

Ophthalmoscopic signs are, refracting media all transparent except the vitreous, which though it obstructed, did not prevent inspection of the fundus. Quite a large atrophic spot (scotoma) of irregular shape in the choroid is revealed, situated very near the site of the macula lutea, the latter could not be distinctly detected. Extensive œdema of the retina was present.

Under treatment of full doses of Pot. Iod., and ergot, in ten days its density had appreciably diminished, especially observable at the periphery. The use of remedies internally was re-inforced by that of galvanism. Under date of Nov. 22, she writes, "there is a perceptible loss of vision in the affected eye, the ellipse is more dense; but a bright speck or opening in its equator on the nasal side has appeared." Believing this to be a favorable indication, I desired her to return to the city, which she did, December 3d. Objective signs had undergone no palpable amelioration. Placed her immediately on pills of Hydg. Prot. Iod. gr. ½, three times a day. In the short space of three days, the opening (fenestrum) referred to had apparently enlarged and assumed a triangular shape, and through this direct vision was possible. Four days later the triangular opening had perceptibly enlarged, presenting a jagged margin, the periphery of the opaque elliptical disc underwent the same modification, besides a diminished density. Vision also improved, she now being able to discern some of No. XX (i. e.) letters about three-eighths of an inch in length. Besides the pills mentioned, I employed galvanism twice daily, with entire relief of the neuralgia which had

been quite a persistent symptom, and of contributing to the achievement of great amelioration of vision. After remaining for a week under this treatment she returned home with directions, under the supervision of her medical advisor to continue the pills, alternating each week with Pot. Iod.

III. The third case was that of Mrs. S. 30 years of age, a colored woman of large stature and healthy; married but has had no children, who consulted me Oct. 27th. On a certain evening about two weeks previously during a domestic jar, she received upon the right eye a blow from the hand of her husband. From this she observed no immediate effects, but in the morning following, even before rising, all objects with the right eye appeared very dim and of a light green color. Vision has since gradually declined, till now she can scarcely discern even the form of large objects at even five feet distant. At this distance the flame of a lamp is obscurely seen and much elongated. Objects by day appear of a dark green color, and very dark, almost black at night. No pain in eye or head at any time, though the eye has seemed too large for the orbit. She is not subject to headache, catamenia regular, no suspicion of syphilis, nor addicted to intemperate habits.

Ophthalmoscopic signs: All dioptric media are transparent, papilla and fundus well defined, retinal arteries are few and very much attenuated. The macula lutea clearly defined, of a cherry red color, very dense at centre, but fading in density to its circumference. It has a diameter of about one line, and situated in the centre of a white spot, (scotoma) of the shape of an irregular parallelogram, demonstrating atrophy of the choroid from œdema. Under treatment similar to that pursued in the former cases, vision improved to a considerable degree, but on account of the irreparable injury sustained, it can never be restored to that formerly enjoyed.

IV. The fourth case is that of Mr. R. of this city, fifty-nine years of age, a shoemaker by trade, who presented himself on Dec. 13th. One week before this date while engaged in his customary work, sewing shoes, hand work, without the slightest premonition or antecedant cause, he suddenly observed vision in his right eye to become almost totally annihilated; peripheral vision was retained in a slight degree especially at external canthus. General health good, though he has had occasional visita-

tions of articular rheumatism to a slight degree, but never incapacitated for work. Has never had headache but twice in his life and then not severe; inclined to constipation; no syphilitic history.

Ophthalmoscopic signs: The anterior refracting media are transparent but the vitreous, hazy to a considerable degree. Still the papilla is discernible and of a much whiter color than normal; the arteries are much diminished in size and resemble red threads. A hemorrhagic extravasation is observable situated above the papilla (inverted image) about one-third its diameter distant. The macula lutea is plainly seen, though somewhat obscurely on account of the opacity of the vitreous. It presents the appearance of a nucleus of dark red color centrally, but fading off to its circumference till lost in the dense infiltration surrounding it. The diameter of the entire efflorescence is about that of the papilla. The space intervening between it and the optic disc is also of a greyish white color from sub-retinal œdema. The pupil responds imperfectly to atropine. Since the invasion of this affection he has experienced an obscure pain in the right mastoid process. The treatment ordered was Pot. Iod. and Pot. Brom.; but prognosis unfavorable to the last degree. I desired him to return in two days for further observation, which he has failed to do.

I may add that in all cases of embolism of the central artery of the retina, the lesion is a very grave one, and the prognosis, as regards ultimate restoration of vision, is extremely unfavorable. And it is to be feared that even the amelioration in any case gained, may prove transient, and atrophy of the optic nerve with its attendant consequences will speedily supervene.

TRI-STATE MEDICAL SOCIETY.

Article XXVIII.

A Stenographic Report made by the Journal's Reporter.]

Puerperal Peritonitis.

Dr. J. A. Ireland of Louisville.—Mr. President and gentlemen of the Tri-State Society. I am unexpectedly called upon to open this discussion. I have had no time in which to make any especial preparations; for this reason I will ask only a few minutes to make the opening remarks. What do we understand by puerperal peritonitis? We have a great variety of opinions expressed with regard to puerperal fever or peritonitis for indeed we have few cases of puerperal fever without puerperal peritonitis. Some authors are decidedly of the opinion that we have a specific disease known as puerperal fever, whilst others are equally positive that we have no specific disease, every so-called case of puerperal fever is really one of septicæmia, accompanied very often by cellulitis, peritonitis etc. In the books we have beautiful discriptions of pelvic cellulitis and pelvic peritonitis. I think however, that upon making a post-morten examination you will scarcely ever see a case of pure pelvic peritonitis. Along with this we have what is called puerperal fever; this name is a very unfortunate one as it doesn't signify anything with regard to the pathology of the disease.

I would like to hear an expression of opinion with regard to the communicability of the disease. I say this because I know there is a vast difference of opinion with regard to the contagiousness and infectiousness of the disease. These two terms have been so blended that they have been made to mean almost every thing so that I prefer the name or rather word "communicability" At one time the almost universal opinion all over this country was that this disease was not communicable—physicians all over the country took this ground. Dr. Tyler Smith went so ar as to say that if a physician visited a patient, who had puerperal fever, the poison would settle in his clothing, in his head, in his

nails etc, and upon his visiting another patient would communicate the disease to her. For this he(Dr. S) adopted a very careful course of bathing, and disinfecting of his person and clothes after visiting a patient with puerperal fever before he visited another patient in the puerperal state. Dr. Meigs taught that puerperal fever was communicable. I have not had as much practice in this disease as some others, but so far as my experience goes, I have no more doubt that the genuine puerperal fever, so-called, is a communicable disease than I have of my own existence. There are men in the profession and some in the city in which I live, who hold that the doctrine of the communicability of this disease is nonsensical. If the disease is not communicable why do we sometimes find it traveling with and following the track of one particular member of the profession all through a community while other gentlemen who are practicing in the same neighborhood, delivering children without any occurence of the disease in their patients? Dr. Horner of our city, not long since told me that when he was a boy and lived in Philadelphia he remembers distinctly, that Dr. Meigs locked up his house and went to the country simply because the disease was following him all around the city of Philadelphia. I have seen similar instances in the country where I live. I have known a physician to deliver a woman who afterward got puerperal fever, he visited case after case in the community and carried the poison from one to the other.

I don't know what relation there may be of this disease to puerperal fever, or erysipelas, scarlatina, or measles, but we know that it is very liable to occur during the prevalence of these diseases; we know that it is more likely to occur during the prevalence of erysipelas, or of scarlet fever than any other time; we know that if a man makes a post-mortem examination of one of these cases and afterwards delivers a woman, she is liable to have puerperal fever.

DR. MAUGHS of St. Louis.—I came in just as Dr. Ireland was concluding his remarks. I may say *in limine* that I cordially agree with him, perhaps, in all that he has said. The communicability of puerperal fever is, however, still a disputed point. The most distinguished men in the profession in the United States—Fordyce Barker and others—united in the opinion that it is a specific disease—a peculiar kind of fever that is *sui generis*. Dr.

Meigs refers to cases of puerperal fever where he thinks the disease was communicated by means of the fingers, clothing, etc., of the physician, and thus he concludes that the disease is communicable. But there is a kind of puerperal fever, so-called, that is not infectious, there are some epidemics that are scarcely communicable; thus, a pneumonic disease is scarcely communicable, that is, it is not ordinarily so. It prevails through the country without communication from one patient to another.

Puerperal fever is auto-infections and hetero-infectious. It is produced in most cases; it is produced as well as aided by putrid discharges, poisons which arise from the epithelium or mucous membrane immediately after the birth of a child. Pieces of epithelium are removed and the blood-vessels being patulous, are ready to absorb the poisonous matter. The gaping sinuses are ever ready for the introduction of septic matter. It may be a blood clot is taken up and, as it decomposes very readily, is absorbed and a condition is present, that, in the course of time, developes septicæmia. It happens in this way in most cases. They are auto-infectious—produced by auto-infection in many cases. But it must be borne in mind that puerperal septicæmia is infectious and it is so to the last degree. Many physicians are perfectly ignorant of the dangerous character of septicæmia, from its auto infectious nature and its hetero infectious nature. The physician goes from a case of erysipelas to his lying-in patient, and communicates the erysipelas to her directly and she dies of puerperal fever. The erysipelas inflammation spreads rapidly and the case is almost hopeless because the puerperal peritonitis almost never results otherwise than fatally. But in their ignorance of the infectious nature of these diseases and of the fact that erysipelas in an individual may be correlated with puerperal fever in the lying-in woman it has been the habit of some physicians to go directly from a case of erysipelas to the bedside of the lying-in woman. It has been so in a multitude of cases. I think it is wrong. The physician should bear in mind constantly the danger of attending cases of zymotic diseases and then hastening directly to the bedside of the lying-in woman. Erysipelas is correlated with puerperal fever undoubtedly, internal erysipelas and puerperal septicæmia, and puerperal erysipelas is rapidly fatal. Now if a physician has a case of puerperal fever, being ignorant of the communicability of the disease, continues his regular practice, visiting five, ten, or twelve lying-in

patients, the probability is that he will carry the disease from one to the other, and an epidemic results. Had he taken the the proper precautions, the disease might have been confined to a single case. Physicians should always bear in mind the fact that zymotic diseases are correlated to puerperal fever and thus avoid spreading this disease.

During the prevalence of scarlet fever, measles, small-pox and other zymotic diseases, but especially of scarlet fever and diphtheria, the danger should be borne in mind. An infection which in the ordin ry individual would produce scarlet fever, in the puerpera would be probably puerperal septicæmia. And so with erysipelas, what communicated in any other manner would be erysipelas communicated by absorption of morbific matter from the vagina—the zymotic matter entering directly into the circulating fluid of the womb,—becomes puerperal septicæmia. This point is universally believed, I think. It is the practice of some physicians to go from a case of erysipelas, walk around the block and go right into the presence of the lying-in woman. They thus carry contagion in their path, of course. If I am attending a case of erysipelas—I don't usually attend such cases—but if I am obliged to attend such a case, I do not attend any obstetric cases. The doctrine was promulgated some time ago by Dr. —— that if a physician was attending a case of puerperal fever, making vaginal and uterine injections, and coming constantly in contact with septic matter, before attending any other patient, he should change his clothing, take a warm bath, and use carbolic acid in order to thoroughly disinfect himself. Then he can go to the next case with comparative impunity. In these cases we cannot rely upon medication. The only way to deal with it successfully is to cut off the supply and then the patient may survive the attack. We should resort to disinfectant washes—washing out the uterus thoroughly and keeping it washed out so there is no odorous discharge—none whatever. In that way we at once cut off the supply and give the patient the best possible chance. At the same time the temperature must be watched and regulated so as to keep that from destroying the patient before the poison is eliminated from her system.

DR. BAUER of St. Louis.—This subject seems to me to be an intricate one, although it would seem to be exceedingly transparent from the statements we have just heard. The subject is

a very intricate one, and we are not yet clear as to the points—we have not yet struck bedrock. But a short while ago we were taught that it was dangerous to touch the peritoneum. We know that we can open the abdominal cavity at any time you please and for any length of time, providing you do not expose the internal cavity long enough to produce anæmia.

You can blow air into the peritoneal cavity with all the germs of bacteria and bacilli as long as you please and it does no harm and is followed by but little inflammation. I have recently read an article from the pen of an Italian gentleman who has made thirty-seven ovariotomies for various objects, for pelvic cellular abscess, for tubal-pregnancy and so-forth, and but one patient out of the thirty-seven died, and that patient was doomed to death almost, when he touched her. Thus we have learned from experiments that you can fill the entire abdominal cavity with milk and in the shortest possible time it will be absorbed and digested by the substance of the body. That is our knowledge now, and how much we may learn yet we don't know. We are just on the threshold, and the questions are not easily disposed of, as we have just heard. That foul material produces septicæmia is, I think, a well established fact. It is for the reason that when a surgeon allows this foul material to accumulate in a wound—the germs of these microscopic organisms—he produces septic infection there, that Prof. Lister cautioned us that we must keep the wound exceedingly clean. But Lister goes into details beyond necessity.

Suppose that you take away a piece of peritoneum and clear the sore surfaces where the secretion will necessarily issue, you get the food for the bacteria and bacilli and they will will develope there in the shortest imaginable time. But with regard to peritonitis, it is without any exception, one of the most fatal and destructive diseases that the surgeon can meet with; but we have learned to protect ourselves against that. I have heard a good deal about septic peritonitis, this infectious agent which the gentlemen have just spoken of, and I should like to know how septic peritonitis comes about. Now two ways have been mentioned in which septic peritonitis might originate. One is, that the infectious material is carried into the vagina and into the uterus. Now this may cause inflammation of the uterus itself, but the peritoneum does not participate in it all this time, nor can it. In order to get septic peritonitis I think it is neces-

sary to have the infectious substances developed within the peritoneal cavity. You must get the germs into the peritoneal cavity. But I don't think you will get septic peritonitis by the carrying of the poison into the uterus, for if it pass into the womb it will be absorbed by the veins and you get septic phlebitis; from septic phlebitis you will get symptoms of peritonitis but it is not septic peritonitis—none whatever. You get a regular inflammation of the peritoneum and very often you get all the products of an active peritonitis. I should think this is the explanation of it. I have had very limited experience in this matter, but my experience and my reading teach me that. Now gentlemen, what is possible to do with antisepsis, and what we can do in the way of peritoneal surgery, is really wonderful. I performed about three months, or rather ten weeks ago, an operation to remove a very large tumor which occupied the entire abdominal cavity, pressing the intestines and the abdominal organs into a very small space. I did not have a very accurate diagnosis, and the patient couldn't help me at all. I knew it was a large cyst—a multilocular cyst. I cut into the abdominal cavity and dealt with facts as I found them, as I preferred this to paracentesis as I wished to avoid the contact of the amyloid substance of the cyst coming in contact with the peritoneum; therefore, I did not choose to make the puncture. I took the chances as to what I might find. My patient, a colored woman, knew very little about anything outside of herself, and still less of herself. How this tumor came there she doesn't know. It was there when she first noticed it, and it was then pretty large. She made a good joke of it and said she thought it might be the cucumbers or potatoes which she had eaten the evening before. Well I did not know whether it was an ovarian cyst, or whether it was fibro-cystic tumor originating in some other part of the pelvic cavity, but I was prepared to deal with it as I found it. I opened the cavity and punctured a large cyst which happened to be multilocular. We found that a number of fibrillæ right in the centre of the cyst went down and connected with the uterus, and it was surrounded with a great deal of indurated material such as we find in these tumors. I was surprised now to find that the lateral ligaments had been raised up with the peritoneum almost midway on the tumor. In order to remove the tumor it was necessary, either to take out a piece of the uterus, or else leave a piece of the tumor; I chose the latter. I took out both the

lateral ligaments. I used the thermo cautery to cut off the lateral ligaments, then I took out the tumor leaving a slight cap remaining as it were. I then charred all over it with a hot iron, and closed the abdomen. I expected no less than death in this case, but the woman got well and she was returned to her home in seventeen or eighteen days.

Now, gentlemen, who could have done that twenty years ago, or even ten years ago, and have had success in such an operation? No man was more surprised than I was. The patient on the other hand, was not at all susprieed; she expected to get well. But the doctor expected her to die, and was greatly disappointed and most agreeably so. We are not yet fully acquainted with the best antiseptic means, gentlemen. It isn't but a very short while since every surgeon used carbolic acid for everything. In the last meeting of the International Medical Congress, Mr. Keith said, right in the presence of Mr. Lister, that he had to give up the use of carbolic acid in his last Battey's cases. He lost all of them by carbolic acid if he used it strong, and if he dilutes it too much, it is of no use—it doesn't kill the germs and these microscopic organisms are developed in that locality. But gentlemen I know that they will live in it, they remain alive, and remain capable of developing in the carbolic acid. Gentlemen may prevent suppurration and septicæmia by its use but when it is once established it takes its course and you can do nothing with it. But why are we not furnished with statistics by Mr. Lister. I happen to have performed quite a number of operations of amputation of the thigh, which, as you are aware, are of a very dangerous character. The percentage of death in this operation is very considerable, yet I succeeded without carbolic acid, and lost but ten percent. of some fifty cases. I lost only five cases out of fifty-five. Lister lost in about the same number, fifteen cases and of this number, six amputations were minor amputations. So that when I compare my statistics and the results of my amptutations with those of Lister, I find I have done better without carbolic acid, than he has done with it. What did I do, gentlemen, with my amputations? I took good care from the first. I made it an especial point first and foremost to arrest the bleeding, and I made the flap operation and smaller than the circular operation. I have taken great care to ligate every vessel that was large enough to ligate, so that I should have no further tronble, when once I had closed the

wound it should not be rendered septic again. After that I close the flaps very gently and lightly apply my sutures and put the limb in a cotton pad. I bandaged the limb and after that put on oiled silk. That is my whole treatment, gentlemen, I do nothing else. Prof. Porter some 25 or 30 years ago advocated this treatment, and therefore, I can't claim any originality.

He said very correctly, nature heals wounds. You require no adhesive straps. You don't require a circular bandage, on the contrary, both of these remedies interfere with the healing process. He advises that the arteries be ligated. The surgeons present at the International Congress declaimed very bitterly against Mr. Lister because he didn't come around with his statistics. He made speeches, but he doesn't say what he has done. My honest belief is he is afraid to publish his statistics. So too, with antiseptic washes. I think if you keep the wounds properly cleaned you will have no trouble. Your antiseptic lotions do no more than wash off the germs—those microscopic organisms. Clean water will do the very same thing, and I use nothing else but clean water on my amputations, and I think they have given me better results.

Now take the spray. Well gentlemen, you know we couldn't live without the antiseptic spray. Now the spray is colder than the atmosphere, and when you spray the abdominal cavity, especially in the portion by the peritoneum you take away the heat, you reduce the temperature which is absolutely necessary for the prolongation of life. That is not all. The air is filled with minute organisms and your spray washes them into the wound—collects them and washes them into the wound. That is the reason that Bilroth and other European surgeons dispensed with the spray. I say the spray cannot do any good and it is likely to do a great deal of harm. I believe the best antiseptic remedies we possess are cleanliness and water.

DR. SCHENCK, of St. Louis.—Mr. President; I came here this evening for the purpose of being a listener; but it is very difficult to be quiet when a subject of this kind is under discussion. It is a subject in which every one is interested. Not only the profession, but the laymen; not only the laymen, but the layman's wife; not only yourself, but your children. And, gentlemen, there is no subject in medicine that I know of that has called forth more medical literature than puerperal fever.

Dr. Barker several years ago gave the number of communications and contributions that had been written on this subject; and a year afterwards he said he had not gotten one-quarter of them. Gentlemen this is the hydra-headed monster of the lying-in room. The people of England, desiring to get at some certainty in regard to the communicability of this disease, called together a meeting at the Medical Congress and discussed it, and by special invitation sent over to this country for Dr. Fordyce Berker to represent us, and when they met they discussed this matter and requested all physicians to report peculiar circumstances in such cases. Gentleman, the profession is ignorant on this point. I remember when I first went into the profession, I thought that every woman in the puerperal condition had puerperal fever, and it frightened me.

Gentlemen, we call peri-cervitis and peri-metritis puerperal fever. And so we call a great many things puerperal fever which are not. I tell you there is a disease such as puerperal fever. Now some gentlemen say it is septicæmia. There is putrid matter in the womb. There is a disease of that kind. The patient has quick pulse, high fever and pains; on examination of the womb you find some putrid matters; you give an injection and down comes the pulse, down comes the temperature. This is septicæmia; call it septic peritonitis if you please. Account for it as you will, it is there. But this is a different disease from what you will find when you have puerperal fever. I am not free from it? Anyone is liable. But what surgeon will tell you he ever saw septicæmia running through a country. Who ever heard of sepiicæmia becoming an epidemic? But septicæmia is not puerperal fever. Call it what you will. Call it septicæmia if you please. It is a distinct affection from puerperal fever. I have charge of a lying-in institution here and I remember very well when I first took charge of it I was frightened at every case of septicæmia, every case of blood-poisoning. I was expecting puerperal fever in everything and I knew it when it did come. It went through my wards like measles go through an orphan asylum. Our institution did not lack cleanliness, but this disease went through the house like the measles goes through a family of children who have never had it. There is no use in cleaning things, it does no good. Don't say your patient has puerperal fever because she has had a child. You can do as you like, gentlemen, cleanliness is near to Godliness. You can wash the womb out when you have got septicæmia. Let the patient have quietude and rest, but if your patient has puerperal fever, be separated from the rest. I think we should be careful to make a distinction between these diseases; between peritonitis and puerperal fever.

Periscope.

Article XXIX.

MATERIA MEDICA AND PHARMACOLOGY.

Gaillard's Medica Journal has the following synopsis of an article written by Dr. Cullen of Richmond, Va., and which appeared in the *Virginia Medical Monthly*:

New Remedies by Charles R. Cullen, M. D., of Hanover County, Richmond, Va.—*Viburnum Prunifolium.*—The black haw bush or small tree, everybody knows; but medicinally, very few know that the profession have in it a real remedy in threatened abortion. or flooding after it. I was called to a lady in her seventh month of pregnancy, with violent pains coming on every five minutes, and which had been increasing for several hours. I gave her at once one drachm of the fluid extract, with thirty grains of hydrate of chloral. In an hour the pains moderated some little, and I repeated the viburnum, with twenty grains of chloral. Two hours after, I gave the same and the pains subsided. The patient slept several hours. In six or seven hours the pains returned again, and I again gave one drachm of viburnum, and twenty grains of chloral; I gave three doses, subduing the pains. Being called away to a labor case, I was absent *twelve* hours, and being sent for hurriedly, I found my patient, as before, with more violent pains, and the os uteri opened three-fourths of an inch. I repeated the same doses four times, and the pains subsided. This condition continued about eight days, but required less chloral each day. Every three or four hours I gave milk freely, keeping the bowels open by enemata. The patient bore the medicine well, and made a good recovery; and two months afterwards went through her labor satisfactorily.

I had often tried hydrate of chloral and other medicines vainly, to check abortion or miscarriage, after the womb commenced opening.

Two months afterwards I was called to a similar case in threatened abortion, with flooding. I gave the viburnum alone, as I desired the patient to be awake in order to report hæmorrhage. In two hours the pains and hæmorrhage both ceased, with good recovery.

I was called last year to another patient—flooding dreadfully—and the contents of the womb were partially removed. I gave viburnum and ergot, and used hot-water injections, with the bag syringe (otherwise called fountain syringe)—a great improvement on the rubber bulb. The flooding was violent, and required continuous use of the syringe and medicine for two days before the hæmorrhage ceased. The abortion was complete.

A short time since I was called again to the same lady, in her seventh month of pregnancy, with violent pains every seven minutes, but no flooding. I gave viburnum and chloral, as before; but the stomach rejected three doses in succession. I then gave four drachms of viburnum and eighty grains of chloral by enema. In one hour the pains moderated somewhat. I gave half the quantity for the second dose, and the pains gradually stopped without further trouble. I used the fluid extract prepared by Parke, Davis & Co., of Detroit.

If this preparation is not accessible, I would use the decoction of the fresh bark. The profession can rely on this remedy, and doubtless many lives will be saved by its prompt use.

Cascara Sagrado, or Rhamnus Purshiana.—I have used this drug for two years, and find it excellent for constipated bowels. When the rectum is torpid, and no other organ is affected, cold water enemata often restore regular passages, particularly after hard labors; but everything fails to act after one or two passages, and this drug proves a good remedy, and requires small doses. It is thought to act by toning the bowel to its natural function; but whatever the theory may be, its good effects have been acknowledged by hundreds of people wherever it has been used. When this remedy fails to act, as it does sometimes, I add one or two drops of the fluid extract of belladonna, and natural passages are obtained.

Berberis Aguifolium.—Having several scaly diseases which arsenic, iodine, and other alteratives failed to cure, I used this drug by itself, and with success. One case was cured with a pint of the fluid extract; another with two pints; and some others

required more. Where constipation or torpid bowels existed, I added the cascara sagrado; and for convenience, I had several thousand pills made, for the cases requiring both medicines; but would prefer the fluid extracts. In several cases of syphilis, the disease yielded very promptly, and without the use of any mercury. As an alterative of the blood, I doubt if this drug does not take its place beside iodide of potassium. Not having had the experience in many of the diseases reported, I am unable to furnish any results from its use, as given in the various journals by practitioners all over the country.

Some physicians report cures of *cancer* from the use of this drug, but not having used it in a single case, I merely mention it, and in connection with the other new remedy—*Chian turpentine*. Whether either or both have any virtue in a genuine case of cancer, remains to be seen and tested by the honest and truthful part of the profession.

I would digress for a moment and report my experience in cancer, and would state that in every city, from Boston to San Francisco, I have looked after cancer cases, with the treatment adopted. Before the late sectional war, I visited a cancer hospital adjoining the suburbs of Memphis, Tenn., and remained all night with the proprietor—formerly a tailor by calling, who got large fees by cancer curing, as he advertised it. I saw forty patients, and probably only four cases of cancer—three of which the cancer-doctor admitted were hopeless. The others were ulcers and tumors of every kind. Some of them very large and easily cured—as the oily-encysted tumors—and for all of which large fees were obtained from wealthy planters. Since the war I visited a cancer hospital in Philadelphia, but saw only some mild cases. Not being admitted within the hospital, with the assistance of a prominent surgeon, we visited many of the cases reported cured throughout the city, but no one case had a physician's certificate that it was a *cancer*. A late report on cancer by a German physician, reports one case in fourteen cured; and doubtless if the cured cases had lived a while longer, the cancers would have returned. While not incredulous about cancer cures, it is best to wait awhile and see results. The concurrent testimony of experienced and honest men should take precedence of money-making quacks.—[*Gaillard's Medical Journal.*

PRACTICE OF MEDICINE.

A CURE FOR HICCOUGH.—*Le Scalpel* gives a very easy cure for a continued singultus, sometimes complicated with spasm of the glottis, introduced by Rostau and highly recommended by Deghillaye, of Mons. It consists in placing the hand flat upon the epigastrium, immediately below the ensiform cartilage, and making firm pressure. Should this prove unsuccessful, place a firm roll of muslin on the same place, securing it by a napkin bound tightly around. In an hour this may be removed, and it will be found that the hiccough has entirely disappeared.—[*Boston Jour. of Chemistry.*

CHRONIC GENERAL PERITONITIS.—In the December number of the *New Medical Journal and Obstetrical Review*, Dr. Alfred L. Carroll, of New Brighton, New York, records an interesting case of chronic general peritonitis, which seemed to have taken its origin in an old pleurisy on the left side, the inflammation passing through the diaphragm and causing at first a perihepatitis, or perhaps an intermediate perisplenitis. The case exemplifies a condition that has been classed among the curiosities of mddical experience, for chronic general peritonitis, independent of tuberculosis or carcinosis, is either ignored or its existence denied by most writers, save as a protraction of an acute purulent attack, and the few who recognize its existence differ as to its pathology and clinical history.

OBSTETRICS AND GYNÆCOLOGY.

ACCIDENTAL ANTEPARTUM-HÆMORRHAGE.—Dr. Edward L. Partridge New York, Physician to the Nursery and Child's Hospital, contributes to the December number of the *New York Medical Journal and Obstetrical Review*, an article in which, after briefly reviewing the current doctrines concerning so-called accidental hæmorrhage preceding the birth of the child, he boldly challenges the expediency of the practice of rupturing the membranes. He believes, first, that rupture of the membranes does not meet the indications—*i. e.*, it does not in itself or in its results offer any reasonable probability of checking the hæmorrhage—and secondly, that the method is highly dangerous from the increase of facilities, for loss of blood,

and because it adds to the difficulty and danger of the proper subsequent steps in treatment. As to whether it really does check hæmorrhage, it can not do so unless a decided decrease in uterine bulk can be secured and maintained thereby. There must, therefore, be a considerable number of cases in which, a small amount of liquor amnii being present, and the reduction in size being very slight after its escape, no benefit can accrue. In cases which present an average amount of amniotic fluid, after its evacuation the uterus is decidely, though not greatly, diminished in size.

What is to show, however, that this decrease is sufficient to close the mouths of bleeding vessels? There is no practitioner who can not affirm that alarming hæmorrhage does often threaten after the birth of the child, and before or after the complete separation of the placenta, when the uterus is *greatly contracted*. Even this degree in the reduction of bulk fails to close the uterine sinuses in the intervals of contraction. All those writers who advise rupture of the membranes couple with this advice the information that there is danger of continued hæmorrhage. One says, "Of course there is risk," while all suggest methods by which they think a loss and a large accumulation of blood can be prevented after the escape of the amniotic fluid—these suggestions looking toward the maintenance of contraction. Accidental hæmorrhage usually takes place prior to or during the occurrence of infrequent and slight early uterine contractions, when the os is slightly dilated or not at all. Superadded is the condition of collapse. If the liquor amnii is now permitted to escape, can any candid, practical obstetrician admit, the author asks, that there is any known way by which a momentary reduction of uterine bulk can be maintained for a period which will check an alarming hæmorrhage?

The uncertainties and tediousness of efforts at excitation of the uterus in cases of induction of labor, afford a good illustration of the difficulties which would be encountered. Ergot is uncertain and almost valueless, for the stomach will either reject or fail to absorb it; or, if absorption does take place, or if the drug is given by the hypodermic method, its action is imperfect when there has been a great drain upon the vital powers. The abdominal binder can not be applied in a way to crowd the resilient uterine tissue into contraction. Manual efforts can not be kept up with any precision or efficacy during a period necessary

to check the hæmorrhage and keep it in control. Good uterine action can not be excited when the uterus is surprised into labor. Good labor-pains will not occur when the patient is exsanguinated. The suggestion of Leishman, to the effect that the placenta will be compressed between the uterus and the child after the escape of the liquor amnii, and hæmorrhage thus be checked, is, Dr. Partridge thinks, fanciful; for no sufficient uterine action will take place to effect this. There are a great many chances also that the part of the child nearest the placenta would not be one which could make an even, perfect compression, if suitable uterine action did take place. Far from meeting the emergency, the method greatly increases the dangers. If the uterus does not contract promptly, and permanently after the escape of the liquor amnii, an ample space is afforded for a furthur extravasation of blood. A very limited space will afford room for a dangerous extravasation.

Another danger is from a more extensive detachment of the placenta when the uterus is even temporarily contracted. Another objection to the early removal of the liquor amnii in accidental hæmorrhage is, that an obstacle is created to the use of the most efficient method for securing dilatation of the os—i. e., by dilators. Their use would be improper, lest, acting also as a tampon, they should prevent egress of effused blood, and add to the accumulation. A fourth danger will be from the increased difficulty encountered in the performance of version if the child is not surrounded by liquor amnii. This operation is often imperatively demanded in the treatment of accidental hæmorrhage, under circumstances, too, when its ease of performance is of great importance. There is one class of cases of accidental hæmorrhage in which the amount of blood lost does not fully explain the degree of shock. In these the factors in the production of collapse are the over-distension of the uterus and consequent irritation of the peripheral nerves of that organ, as well as the abstraction of blood from the circulation. Here, then, we might believe, was found sufficient ground for the treatment by early rupture of the membranes, relieving thereby uterine distension and the resulting irritation to the nervous system. Upon consideration, however, we find, first, that it is impossible to prejudge in these cases. It is only *after* delivery, when the amount of effused blood can be estimated, that we discover that the shock was proportionately greater than the hæmorrhage. Again,

collapse brought about in this way, does not obstinately refuse to yield to treatment, but will be remedied usually by the customary measures, such as stimulants, the application of external heat, etc., without the need of any decided local interference. Finally, this variety of the accident is not very common, as indicated by clinical records, the possibility of its occurrence being so lightly regarded as hardly to be mentioned by writers.

What, then, should be the treatment looking toward the safety of mother and child when immediate delivery can not be resorted to, owing to incomplete dilatation of the os? By all means *preserve the membranes intact,* and thus tampon the uterine cavity with liquor amnii. Then, in the great majority of cases, employ Barnes's dilators until the desired result is obtained. Of course, this or any similar treatment must be employed at a suitable time. It must not supersede efforts for the relief of collapse, and it may be necessary to defer all operative measures until the patient can be rallied from the alarming constitutional symptoms. The os being sufficiently dilated to enable delivery to take place, rupture of the membranes is proper, and should be followed by manual efforts to compel the uterus to descend upon the child, whose expulsion should be immediate. Version fulfills the indications better than the forceps, as by the former operation there is less danger from delay during delivery, and because it can be successfully resorted to at an earlier period in the dilatation of the os than the forceps can. Bimanual version should not be considered for a moment, as in cases most favorable it can not always be accomplished, while in this accident the irregularity of the internal uterine surface caused by the collection of blood would certainly interfere with the change of position of the child. During the entire time stimulants must be freely used and warmth to the surface, and in exceptional cases, when the hæmorrhage does not appear to be continuing, it is proper to wait for returning vitality before operative measures are undertaken, lest the condition of collapse be aggravated. The danger is not necessarily over after delivery, for it is often difficult to bring about reaction from the dangerous condition, and convalescence will often be slow.

DISEASES OF CHILDREN.

SUNLIGHT FOR CHILDREN.—The *London Medical Times and Gazette* remarks: "Sir James Paget, in his address at Cam-

bridge last August, suggested as a good subject for a scientific thesis the analogies between a green rose and a rickety child. In our opinion this is the direction in which inquiries must be made if we would solve the difficulties of this really important social question. Bearing in mind the effect of sunlight upon the nutrition and growth of plants, let us ask ourselves whether its privation may not be a most powerful factor in the growth and development of infants. Is it not very probable that an infant under the influence of air and ample sunlight may be able to develop and grow on a diet which, without sunlight, would be insufficient?"—[*Gaillard's Journal.*

ACRANIA MONSTERS.—The comparatively rare occurrence of this form of monstrosity, and the still more infrequent opportunity of post-mortem examination of them, make a case reported by Dr. Emil Mayer, in the *American Journal of the Medical Sciences* for January, 1882, of interest. The body was well developed and very large; the head was small compared with the body, the nose long and flat, the eyelids bulging, and the lips thick and separated. The right ear was fully developed, its lobe lying on a line with the nostril, while the left ear was flat, with its lobe on a line with the mouth; the auditory canals were both normal. Lying directly above the upper lids and the superior portion of the nose, and extending over the whole of the upper surface of the head to the occipital protuberance posteriorly, lay the brain-like tumor, covered by membranes which ran into the hairy scalp on its borders. Anteriorly there were two prominences, between which was a rent made by the finger in delivery. The facial angle was about 60°. There was absence of the whole of the frontal bone, except the orbital and nasal portions, the squamous portion of the temporal bones, both parietal bones, and all the portion of the occipital bone above the protuberance. The medulla seemed to be the only portion of perfect nerve-substance present; no gray cells, or evidence of cerebral brain substance, were present, the tumour being of a connective-tissue character.

MENTAL AND NERVOUS DISEASES.

IS INSANITY INCREASING?—It is a common saying that an increase in the number of insane persons is one of the necessary results of the intensity of modern life. There is certainly a

steady increase in the number of inmates in asylums for the insane, an increase greater than the growth of population would seem to warrant. For this there may be several causes.

1. An actual increase in the proportion of persons of unsound mind in comparison with the entire population.

2. A more general and systematic commitment of insane persons to asylums for protection and medical treatment.

3. A steady accumulation of insane persons owing to the better care of the insane and the consequent lowering of the death rate of such persons.

That the second and third causes are real and potent, is amply sustained by the statistics of our public institutions. The proportion of insane persons at large naturally diminishes with the improvement and multiplication of asylums and the growing popular conviction that neither individual nor public well-being is furthered by allowing the insane to go free, uncared for, and without medical assistance; and as a natural result the number of the insane in asylums increases proportionally.

Accordingly we may have an increase in the number of annual commitments to asylums, as well as in the number of permanent occupants, without any increase in the total percentage of insanity in the country.

Increased efficiency in the medical treatment of the insane may also seem to increase the number of cases as well as the actual number under care at any time. With unskillful treatment many cases of acute mania may result in speedy death, or, what is worse, chronic insanity. In such cases the patient counts but once. With better treatment the patient is ultimately, often speedily, discharged, apparently or really well. The disease is liable to recur, however, and in the course of years the same patient may have to be under treatment several times, each time adding one to the statistics of insanity.

Another fact which tells against the theory that "high pressure" living tends to unhinge the mind, may be found in the source of the larger portion of the inmates of insane asylums. The records of asylums show that most of the insane come, not from the busy professional, mercantile and manufacturing classes, but from those whose lives are a monotonous round of petty drudgery, or, what is equally killing, petty inaction, unfruitful idleness and dissipation. Frivolity probably leads more men

and women to the insane asylum than the hardest and intensest pursuit of mental or material wealth.—[*Scientific American.*

NOSE, THROAT AND EARS.

EXPERIMENT WITH THE EAR.—An experiment illustrating "fatigue" in the sense of hearing (corresponding to fatigue of the retina) has been described by Herr Urbantschitsch. Two tubes are adapted to the ears, and adjusted, so that a given tuning-fork is heard equally on both sides. Now strike the fork strongly, and let it sound a little through one tube; then deaden it somewhat by touching. The ear on that side fails to catch the weakened sound, but on transferring the fork to the other ear, the sound is heard distinctly. If the weaker tone presented be of different pitch from the stronger, it is heard on both sides equally. The failure of sensitiveness in the other case is very transient.—[*Boston Journal Chemistry.*

CATHETERISM OF THE TRACHEA IN CROUP.—A correspondent writes to the *British Medical Journal*, June, 25, 1881, that he was called to a girl, 2½ years old, for croup.

It was evident by the pulse, which was about 150 and almost imperceptible, that unless some relief could be given, the end was not far off. The face gradually became pale, and wore a distressed expression, and the lips were of a livid blue color. As the mother objected to tracheotomy, and as emetics, hot bath, and the ordinary routine treatment, had been previously tried, I introduced a large (No. 12) gum-elastic catheter into the trachea, with less difficulty than I anticipated—having first gagged the child's mouth with a cork, for want of something better, and depressed the tongue with a spoon. After a severe paroxysm, she succeeded in getting a pretty good breath, and the next expiration was followed by the ejection of muco-purulent *débris* and sticky phlegm through the tube. In about ten minutes these convulsive efforts ceased—the child, in the meantime, getting a good amount of air into her lungs. In half an hour her face was flushed, but had lost its lividity, and the breathing was fairly comfortable. The tube was retained by tape tied around the child's neck, and was removed twenty-four hours after its insertion; when the temperature had fallen to 100° Fahr. and the pulse to 110. Five days later she was running about the house, not much the worse for her dangerous illness. I observed hardly any difficulty in swallowing liquids after the first two or three attempts, when the tube was introduced.—[*Med. and Surg. Reporter.*

Clinical Reports from Private Practice.

Article XXX.

Epithelioma of Tongue. By Wm. B. Craig, M. D., St. Joseph, Missouri.

In May last, was visited by Miss H.—— of Iowa, who complained of a tumor situated upon the side of the tongue. The growth had been present, but increasing in size for eighteen months or more, and was due, she thought, to either the irritation caused by a ragged carious tooth, or creosote which she placed on the tooth to relieve pain, and which burnt the tongue. However, no doubt remains as to the etiology in such a plain case, carious teeth being such frequent factors in the production of epithelial growths.

Upon examination, this proved to be an epithelioma, occupying the anterior lateral aspect of the tongue. Its posterior border corresponding to the side of the second molar tooth, the left side was clearly defined and the tissue not infiltrated about it. In fact, it seemed a rather favorable case for excision.

Method of Operation.—Placing the patient near a strong light, upon the left side, and administering an anæsthetic, I proceeded, to introduce the usual whip-cord ligature through the tip of the tongue, in order to ensure the complete control over the organ, then passed a curved needle armed with a short carbolized double thread near the center of the tongue, remote from the diseased portion and tied each ligature upon the sides of the tumor in front and behind in a manner similar to ligating a hemorrhoid.

With the knife the tumor was rapidly dissected out. The slight oozing controlled by Monsel's sol., and the edges of the wound united by a smaller suture than the one first used, yet sufficiently large not to readily cut through the tongue.

The patient required only one dose of opium thereafter, and in forty-eight hours the sutures were removed, and the tongue found to be granulating nicely, so that before leaving for home, the tongue presented nearly a normal appearance and contour. She remained just a week in the hospital.

Have heard from her since and she expresses herself as entirely relieved.

Article XXXI.

Spontaneous Discharge of Gall-Stones Through the Abdominal Wall. By Henry Humfreville, M. D., of Waterville, Kansas.

On the 20th, of Nov., 1881, was consulted by Mrs. V.—— who, for some time had noticed an enlargement and some soreness just at and a little below the umbilicus; her general health was good—better than for years. About three months before consulting me, she had what her physician termed "inflammation of the membranes of the bowels," and since that time she has noticed a soreness at this spot, but not enough to cause any uneasiness. The enlargement was gradual and it was not caused from any disturbance of the general system it caused, that led her to consult me, but a desire to know the cause and nature of the growth. On examination, a pyriform tumor, base upwards, was found occupying the umbilicalegion,
to the surrounding parts, but manipulation caused no pain. Previous history elicited nothing, and the diagnosis was not freely established at that time.

About two weeks after her visit, her husband informed me that the lump had broken on the outside and was discharging a small quantity of serum; an application of cerate dried up this discharge, and three days later, just at the umbilicus, the tumor become painful and red and had a tendency to point. A flaxseed poultice was applied in the evening, and when removed in the morning, there was attached to it, ten pieces of stone, and protruding from the opening were four more; these her husband picked out and with the balance threw into the coal scuttle. Meeting me on the street, he told me about those queer "stones," and asked that I visit her and see what they were. On my arrival at the house she was still in bed, bnt made no complaint. I found twelve of the stones, and upon examination pronounced them gall-stones. Varying in size from a chestnut to a pea, they all fitted, and judging from the twelve, the entire lump must have been as large as a walnut. Each piece was triangular and

the corners rounded off; they floated on water, and when cut open were of a bright yellow color.

A simple dressing was applied to the opening, which was then about the size of a silver dollar, and discharging freely. It closed gradually, and in a few days she was able to be up. No communication could be discovered, with the gall bladder, and the fistula which was anticipated did not exist, although there is still some discharge and the part is very tender.

That the inflammatory attack of the "membranes of the bowels," for which she was treated prior to the enlargement originated in the gall-bladder, is fully established for these reasons. At no time was there the least indication of jaundice or hepatic colic. The passage of a stone half the size of the smallest passed through this external opening engaged in the cystic duct, would produce paroxysms of pain which could not be mistaken. That the impacted concretions produced an inflammatory action in the gall-bladder, that it extended to the parts adjacent, and an attachment through the process of inflammation and a discharge of the concretions through the abdominal wall was the result No part of the concretion, or in fact any stones, unless very small, ever reached the jejunum, and that there still remains more to be discharged through the same channel,is the only conclusion to be drawn. The effect upon the general system was very slight, none at all, and not enough to excite the patient or her friends, until after the stones had been discharged. At present her general health is good—better than for years—and the soreness around the umbilicus is the only complaint made.

In 1876, the first operation for an impacted gall stone through the abdominal walls was performed, but the patient died; likewise one who was operated on in 1877, and also one in 1878.

Dr. Augner, of France, reports a case in which a spontaneous discharge of one hundred stones, took place through the walls of the abdomen, and the patient (a woman) afterward enjoyed perfect health.

Reports of cases of this nature are rare, and authors say but little on the subject, and consider the prognosis grave. Yet this patient is well, and as able to do her work as any of her neighbors, and unless a fistulous opening should form later by the passage of more concretions; and this is not to be anticipated or expected for some time, perhaps never. It must be considered as remarkable.

Correspondence.

Article XXXII.

Editors Journal:

Some physicians and others of your city and other places, are under the impression that I am associated with the parties in your city operating on animals for the purpose of producing cow-pox virus. Through your widely circulated Journal, I beg leave to state they labor under a false impression, for I am in no manner whatsoever connected the parties. There is a Mr. R. M. Higgins, connected with them who is no Dr.,—being of the same name, the inference with some is that I am the one alluded to when the name is spoken. Theirs is a new enterprise of only a few weeks' existence, whilst I have been engaged, this my seventh year in preparing vaccine on the bovine species, near Manchester Mo., the place where I first began operating. When I change my place of business my many patrons will be duly informed.

This statement is made also in justice to my own reputation, since I am reliably informed that vaccine prepared by these parties, is offered at some of your drug stores as Dr. Higgins' vaccine. Hereafter, each package of 5 quills sent out by me, will have a label on bearing my name and address. I furthermore make this statement in justice to the subject of cow-pox or non-humanized vaccine. You know Mr. Editor, experience is a great teacher, and especially is it so with this subject.

Respectfully,

R. M. Higgins, M. D.

Missouri Vaccine Farm, Manchester Mo.

Obituary.

Article XXXIII.

At a Regular Meeting of the St. Louis Medical Society held January 14, the following resolutions were presented and adopted:

Dr. Isaac Drake McDowell.

Mr. President:

Your committee appointed to prepare resolutions in relation to the death of Dr. Isaac Drake McDowell, report as follows:

Dr. McDowell was born in the city of Cincinnati in the year 1831, and was at the time of his death, fifty years of age. He was the oldest son of the late Professor Joseph Nash McDowell. His mother was a sister of Professor David Drake, of Cincinnati and an aunt to Judge Charles D. Drake, of Washington. He was a brother of Professor John J. McDowell, of the St. Louis Medical College.

Dr. Drake McDowell came to this city in the year 1840, and received his primary education principally in the Public Schools. He was a graduate of the Missouri Medical College; for a time he was Demonstrator of Anatomy in the same institution and was afterwards elected as Professor of Anatomy. He held this position for several years, and was the Dean of the Faculty. After resigning his chair, he engaged in general practice in the town of New Madrid, Mo.

For several years prior to his death he practiced at Hot Springs, Ark. About three years ago he was attacked with serious and complicated diseases of the digestive organs, and which finally caused his death. He died on the 5th, of this month, and his remains were brought to this city for interment. He was buried on the 8th, instant, in the family lot, in Bellefontaine Cemetary.

He was the last of his father's family, and the last of a group of ten children, consisting of five sons and five daughters. He was twice married; the first wife was Miss Provines, daughter

of Dr. Provines of Columbia, Mo., the second, who survives, was Miss La Forge, of New Madrid.

In his career as a teacher, Dr. McDowell displayed talent of a high order, and he was regarded as "a worthy son of a worthy sire." Circumstances, however, conspired to separate him from his chosen sphere, but in his relations as a practicing physician and surgeon, he had the confidence of the profession and community. In view, therefore, of the qualities and attainments of the deceased we respectfully submit the following resolutions.

Resolved, That we record with earnest sorrow the death of our friend and brother. That in his death the profession has lost one endowed by nature with brilliant intellectual powers, a man of fine social qualities, a genial and kind hearted citizen.

Resolved, That we sincerely sympathize with the wife of the deceased, in her bereavement.

Resolved, That this memorial and these resolutions be entered on the minutes of this Society, and that a copy of them be transmitted to the wife of the deceased.

CHAS. W. STEVENS,
S. T. NEWMAN,
G. M. B. MAUGHS,
} Committee.

DR. JOHN W. DRAPER.

The republic of letters acknowledges no defined geographical limits, but wherever throughout its wide domain is found a devotee engaged in the illustration or evolution of the wondrous laws of nature or of philosophy, that one is embraced in the common fraternity and owes a common allegiance.

The death-fall of one who, along life's pathway has erected monuments of his genius, strikes all with surprise; by it a shock is radiated from centre to circumference, and mournful vibrations course along the complex web that binds all in common sympathy. A common sentiment constrains all to give the event fitting recognition and acknowledgement.

Dr. John W. Draper, late of New York City, died in Hastings on-Hudson, N. Y., Jan. 4, 1882. The genius of letters is in tears; assumes the habiliments of woe and proclaims a period of mourning. A kindred impulse reaches and takes possession of the St. Louis Medical Society, therefore,

Resolved, By this Society, that by the death of Dr. Draper,

science and philosophy has lost a zealous votary, an able advocate and a powerful promotor.

Resolved, That, appreciating the eminent talent and exalted achievements of the deceased, this Society shares in the common grief.

Resolved, That, to the family of the deceased and surviving relatives, this Society extends sentiments of sincere sympathy and consolation.

Resolved, That a copy of this action, duly authenticated, be transmitted to the family of the deceased.

F. J. LUTZ,
WM. DICKINSON, } Committee.
M. H. POST,

The following memorial and resolutions were adopted at a regular meeting held, Jan. 21, 1882.

DR. CHARLES SPINZIG.

It becomes our painful duty to announce the demise of an associate member of the St. Louis Medical Society, Dr. Charles Spinzig.

Better than an eulogy, is perhaps a brief sketch of his life, most befitting this mournful occasion.

Dr. Charles Spinzig was born in Hanover, Germany, in 1829; he came to this country in 1852. Wanting the advantage of an early education, he had to engage in the most humble occupation, to earn a support for himself and family. His desire for the acquisition of knowledge grew with every day. Every spare moment was devoted to reading and study, and already in 1856 he felt himself qualified to commence the study of medicine, and in 1858 he obtained the degree of Doctor of Medicine, from the "St. Louis Medical College." He entered at once upon the practice of his chosen profession, which held out to him, as to all true votaries of it, a bright and prosperous career. The war of the rebellion checked for a time his progress. He entered the ranks of the patriots of his chosen country, and served as regimental surgeon during the entire civil war, in Col. Kahlman's regiment.

On the return of peace he resumed his practice. In 1866 he received the appointment of Resident Physician of the City Hospital. An epidemic of cholera was then prevailing in the city.

His opportunities for observation and experiments were good, and he made good use of them.

On the expiration of his term of office, he returned to private life, to hard and successful work in his profession.

His public spirit made itself also known by the great interest he took, and time he devoted to public education. Thrice he was elected, though an independent candidate, to represent the interests of his ward, in the Board of Directors of the St. Louis Public Schools, always defeating the party nominees. He was at last compelled to resign on account of ill-health.

Dr. Spinzig was emphatically, a self-made man. None felt more the want of an early education, and none worked harder to compensate for it. He was an indefatigable, close student, an earnest investigator, and when he once reached a conclusion, he lived up to it unswervingly.

Though engaged in a large and remunerative practice, he was an industrious reader of medical literature and other scientific works. He was a prolific, terse and good writer. His numerous monographs were more read and appreciated abroad than at home. They are original productions—no compilation and no plagiarism.

The following is a list of his most prominent writings :

1. *Variola*, causes, nature, prophylaxis and treatment.

2. *Epidemic Diseases*, as dependent upon meteorological influences.

3. *Cholera*, the laws of its occurrence, non-occurrence and its nature.

4. *Variola*, its cause, nature, prophylaxis and the *danger of vaccination.*

5. *Yellow Fever.* Nature and epidemic character, etc.

6. *Failure of Vaccination*, etc.

These essays on *Variola* and his opposition to vaccination, aroused a great opposition to him, but he was indifferent to the abuses and indignities of his opponents, and that is to say, the whole community. He maintained unflinchingly, his convictions, and lived up to them, which required moral courage far beyond the reach of ordinary men. His professional interest and social standing suffered much on that account. But he felt it his duty to proclaim as errors, those views, which in the pres-

ent century had been regarded as immutable truths. Such a character can only be admired, though it must be regretted that his logic led him to such conclusions.

Such was Dr Spinzig, though derided and ridiculed by many, he was loved and admired by equally as many. The large concourse of patrons, neighbors, friends and citizens at the funeral ceremonies, expresses more eloquently than words, the esteem and love with which he was regarded as their good physician and much honored citizen. Therefore be it,

Resolved, By the death of Dr. Charles Spinzig, this Society has lost a very valuable member; this community a patriotic and good citizen, a friend and promotor of education, a judicious and practical philanthropist.

Resolved, That the sentiments of sympathy and condolence of this Society are extended to the family of the deceased.

Resolved, That the Secretary be requested to send a copy of this memorial to his widow and children.

S. POLLAK,
E. H. GREGORY,
WM. DICKINSON,
CHAS. W. STEVENS,
C. F. V. LUDWIG,
} Committee.

DR. W. DOUGLAS HEMMING.

IT is with a feeling of sadness that we chronicle the sad death of Dr. W. Douglass Hemming, which took place on December, 15, 1881. He had been long suffering from pulmonary phthisis and it suddenly terminated in a fatal attack of hæmoptysis.

Dr. Hemming was a gentleman who was an honor both to himself and the profession. He was an active worker in laryngology, and the JOURNAL and its friends have lost a co-laborer whose future promised a great deal.

PROFESSOR PIROGOFF.

The death of Dr. Nikolaus Pirogoff is announced from St. Petersburg. He was Professor of Surgery to the Medico-Chirurgical Academy in St. Petersburg, and a member of the consulting staff of several hospitals in that city. In 1840, he brought out a valuable treatise on the division of the tendo-Achillis in orthopædic surgery. He also wrote on cholera, on the surgery of the arterial trunks and of fasciæ, and on the medi-

cal aspects of the Caucasus, and on topographical anatomy. His work on this last subject forms a fine atlas of anatomy, as illustrated by frozen sections. It is with military surgery that his name will ever be most closely associated. He is the medical historian of the Crimean and Circassian campaigns; and also wrote a report on the permanent and improvised military hospitals in Germany and Alsace-Lorraine during the war of 1870. The Professor is best known in this country from the operation named for him.—[*Medical and Surgical Reporter.*

DR. BRIQUET.

Within a month of the death of Professor Bouillaud, the Nestor of the Academy of Medicine, the other Nestor, Dr. Pierre Briquet, has passed away at the same age—eighty-six. They resembled each other in their constant attendance at the meetings of that learned body. Indeed, of Dr. Briquet it has been declared that he never missed a meeting since his nomination in 1860. Like Bouillaud, too, shortly before his death he read a memoir, being a kind of supplementary chapter ("Prédisposition á l'Hystérie") to his well-known work on hysteria. He was for a long period Physician to Charité, and wrote on cholera and many other medical topics.—[*Ibid.*

DR. D. WARREN BRICKELL.

The many professional friends of this distinguished teacher will be pained to learn that he died in this city December 11th, 1881, after a lingering illness. In the Feburary number of this journal will appear a biographical sketch from the pen of his friend and colleague, Dr. J. Dickinson Bruns.—[*New Orleans Med. and Sug. Journal.*

Book Reviews.

Article XXXIV.

☞Notice.—In order to secure reviews of books it will be necessary to send duplicate copies of the same. Authors sending reprints will please remit them in triplicate in order to obtain notice in this department. In all cases, where *single* copies of books or pamphlets are sent, a mere acknowledgement of their receipt only will be made

The Principles and Practice of Surgery. Being a Treatise on Surgical Diseases and Injuries. By D. Hayes Agnew, M. D., LL. D. Profusely Illustrated. Vol. II. 8vo. pp. 1066. (Phila: J. B. Lippincott & Co. 1881.) Price $7.50.

The Second Volume of this valuable work is before us. A review of its contents, confirms the opinion formed from reading the first Volume. On almost every page there is evidence that the Author is a careful painstaking collator of existing knowledge. And yet, his individual convictions, formed from his own observations and experience, are always presented with sufficient force of expression to satisfy the reader that he has written the book in accordance with his conception of right.

His habits of practice are strongly indicated as we pass from subject to subject. While he does not ignore Gamghee's trinity of antiphlogistics—"rest, position and pressure"—he repeatedly recommends evaporation and sedative lotions under such circumstances as will lead the young practitioner to use them to the neglect of the (to our mind) more reliable "trinity."

In the treatment of compound luxation, page 28, Prof. Agnew says: "After it is (the external wound) closed, gentle movement should be made to restore if possible the function of the joint." We do not believe the closure of the external wound by cicatrization can in any sense, indicates the time of beginning passive motion. In regard to the reduction of dislocation of the lower jaw, he repeats the old error as follows: pp. 36–37. "The return of the bone into place is announced by an *audible* sound and it occurs with such *suddenness* and *force*, that unless the operator is careful to shift his thumbs over to the sides of the jaws, they may be severely *contused* between the teeth."

In speaking of dislocation of the cervical vertebræ below the second, pp. 42 and 43, the Author finds "The want of regu-

larity which is noticed in the position of the spinous processes may be seen to exist to some extent also in the anterior surfaces of the bodies of the vertebræ, by examining the posterior wall of the pharynx." We would remark that when the dislocation is sufficiently high to be observed it is much more distinctly observed in the pharynx than in the spinous processes, and also that the deviation in the line of the transverse processes is more appreciable than that of the spinous.

The method of securing a counter-extending force by "placing folded sheets obliquely across the shoulders" in reducing dislocated cervical vertebræ is open to the objection, that the muscles connecting the shoulders to the spine, are thus made tense by holding the shoulders downward—when if the counter-extending force were applied to the loins, the Trapezius and Levator Anguli Scapulæ Muscles would not be forced to resist the extension. Direct pressure upon the displaced bone can be of little use, for so soon as the projecting parts of bone are disentangled by extension, the extending force will be sufficient to replace the displaced portions, and until this disentanglement is accomplished no amount of direct pressure can avail.

In compound dislocation at the elbow, the Author advises partial resection, i. e., "to remove the projecting ends of the ulna and radius so that they can be easily replaced and will lie easy and free from all pressure within the wound." In backward compound dislocation the lower end of the humerus projecting through the wound made by itself it can hardly be desirable to resect the lower end of the humerus, since this would leave a comparatively narrow end of humerus for the formation of the new joint. It may also be remarked that in all compound dislocations of the elbow, made compound by the bone perforating the skin, reduction is very easy, and there is never that tension on the reduced bones so objectionable in compound dislocation of the ankle joint; and hence, less propriety in resection than in the latter joint.

The radical position expressed thus: "*Excisions of the elbow joint.*" "The conditions demanding excision of this articulation are as follows: *First* compound luxation with protrusion of the articulatory extremity of one or more bones of the joint," by the Author is one which, if its teachings are strictly followed, will I am sure lead to resection in cases that may recover with better joints without resection.

We are pleased to note that the Author recognizes the possibility of primary inflammatory changes in cartilage. Much nonsense has been written about the necessary primary involvement of the bone or synovial membrane before cartilages suffer inflammatory changes. Much stress has also been placed on the absence of bloodvessels in cartilage, as an explanation of the error that cartilage never becomes primarily involved in inflammation, that one would be led to suppose that cartilage in the

matter of its blood supply, differed in kind rather than in degree from other tissues. It is so often spoken of in this connection as an extra-vascular tissue, that one would be led to infer that authors regarded it as the only extra-vascular tissue.

On page 841, we find Dr. A. holds that hæmaturia may be caused by "the forcible pressure of the viscera by the abdominal muscles against the emulgent veins so as to cause congestion and rupture of some of the renal vessels." We confess we have not the acuteness to perceive that the pressure by the abdominal muscles through the viscera will be greater on the emulgent veins than on the kidneys—and to our mind such pressure would diminish the liability of rupture of veins —when as if the pressure of the vessels were robbed of the support of the abdominal muscles the danger of rupture of the vessels of the kidneys would be increased.

Enumerating the causes of lateral curvature of the spine Prof. Agnew omits perhaps the most frequent cause—pleuritic inflammation.

The volume as a whole and indeed, in its several parts is most excellent, and is a safe guide in the practice of surgery

JNO. T. HODGEN.

ANTISEPTIC SURGERY. The Principles, Modes, Application and Results of the Lister Dressing. By DR. JUST LUCAS-CHAMPIONNIERE. Translated from the Second and Completely Revised Edition, with the special permission of the Author and Editor, by FREDERIC HENRY GERRISH, A. M., M. D. 12mo. pp. 239. (Portland, Me.: Loring, Short & Harmon, 1881.) Price $2.25.

Although Listerism has received several staggering blows lately, there is no doubt whatever, that it has achieved a revolution in the treatment of wounds. The author of this volume is enthusiastic over the method, and to him belongs the honor of having first made it distinctly understood in France. The author has, perhaps, too much faith in Lister and Listerism, still he has had a large hospital experience, and has used in with great success. His description is a clear and pleasing *exposé* of the manner of using, and the cases adapted to Listerism, from his point of view, and is withal, a very valuable work to read. This is, we believe, the first book published in America, on antiseptic surgery, and on that account should be read by all who expect to treat wounds.

The author has not entirely divested himself of certain French phrases which crop out here and there, and show that it is rather a literal than an easy, flowing, liberal translation. However, it

all clear, and if he has sometimes failed to be elegant, he never ceases to be clear.

The mechanical work is unexceptional.

Transactions of the Medical Society of New Jersey. 8vo pp. 306. (Newark, N. J.: L. J. Hardham, Printer, 1881.)

This is a very neatly arranged volume abounding in good papers. The President's address is on Pleural Effusions, with special Reference to Pyo-Thorax. Then follows a Twenty-Five Years' Review of the Society of Dr. Stephen Wilkes.

An Essay on Laceration of the Cervix Uteri, by Dr. G. H. Balleroy, and one on Eye Affections from Malarial Poisoning, are followed by the report of the Standing Committe, in which a review of the most interesting matters in the State, connected with medicine, are given.

Obituaries of ten dedeased members, are next in order, and then come the Reports of District Societies. These are replete with practical points and are clear and brief. Some very interesting papers find their places among these.

The interest taken in the Society may be judged from the fact, that only four counties were not reported upon at this meeting.

Favorite Prescriptions of Distinguished Practioners, with Notes on Treatment. By R. W. Palmer, A. M., M. D. 24mo. pp. 121. (New York: Bermingham & Co. 1881.)

Of course, we are opposed to the blind following of formulæ even if given by the best of authors or practitioners. It, in a measure, destroys the self-reliance and habit of thinking for himself, which every young practitioner should acquire.

On the other hand, there is this advantage, that the methods of successful practitioners may be learned and ideas be suggested.

The above is a good compilation, and if read in the proper manner, cannot fail to be of benefit. Certain of the prescriptions are so well compounded that they could hardly be improved upon, yet we connot refrain from regarding the adoption of these by the unsophisticated reader, as empiricism in its most narrow sense.

The Compend of Chemistry, with which is included a Second and Revised Edition of the "First Step to Chemical Principles." By Henry Leffmann M. D. 18mo. pp. 160 (Philadelphia: C. C. Roberts & Co., 1881) Price $1.00

This is a handy little book for those who need such things as "compends." Dr. Leffman has acquitted himself well of his task;

but we cannot approve of these quasi labor-saving books, which in reality, tend only to give the student enough superficial knowledge to pass an examination.

Landmarks Medical and Surgical. By Luther Holden, assisted by James Shuter, M. A., F. R. C. S. From the Third English Edition, with Additions by William W. Keen, M. D. 12 mo. pp. 148. (Philadelphia: Henry C. Lea's Son & Co., 1881. St. Louis: St. Louis News Co.)

There is little need of commendatory remarks for this little volume. Since 1876, it passed through three Editions and is a help of the greatest value. The additions and hints of Dr. Keen are good and always to the point. This small volume will always make friends far itself, its chief merit lying in its intrinsic value.

Books and Pamphlets Received.

Article XXXV.

The Diagnosis and Treatment of the Diseases of the Eye. By Henry W. Williams. A. M., M. D. 8vo. pp. 464. (Boston: Houghton, Mifflin & Co., 1881. St. Louis: St. Louis News Co.) price $7.00.

Annual Report of the Supervising Surgeon General of the Marine Hospital Service of the United States for the fiscal year 1881. 8vo pp. 247. (Washington: Government Printing Office, 1881).

Necrocis and Elimination of almost the whole Bony Apparatus of Hearing in almost Complete Form. Recovery. By S. Pollak, M. D. (Reprinted from the *Archives of Otology*, Dec. 1881.)

The United States vs. Charles J. Guiteau. Testimony of Dr. Fordyce Barker.

Mansills' Almanac of Planetary Meteorology, etc. By Richard Mansill. 8vo. pp. 48., price twenty-five cents. Published by R. Mansill, Rock Island, Ill.

A Manual of Ophthalmic Practice. By Henry S. Schell, M. D. With fifty-three illustrations. 12mo. pp. 263. (Phila: D. G. Brinton. 1881. St. Louis: Hugh R. Hildreth, Printing Co.)

The Physician's Clinical Record for Hospital and Private Practice; with Memoranda for Examining Patients, Temperature Charts, etc. (Phila: D. G. Brinton, 1881. St. Louis: Hugh R. Hildreth Printing Co.)

Wood's Library of Standard Medical Authors:

A Treatise on Albuminuria. By W. Howship Dickinson, M. D. Cantab. Second Edition, 8vo. pp. 300. (New York: Wm. Wood & Co. January, 1881).

A Treatise on the Materia Medica and Therapeutics of the Skin. By Henry G. Piffard, A. M., M. D. 8vo. pp. 351. (New York: Wm. Wood & Co. February 1881)

A Treatise on Diseases of the Joints. By Richard Barwell, F. R., C. S. Illustrated by numerous engravings in wood. Sec-

ond Edition revised and enlarged. 8vo. pp. 463. (New York: Wm. Wood & Co., March 1881.)

A Treatise on the Continued Fevers. By James C. Wilson, M. D. With an introduction by G. M. DaCosta, M. D. 8vo. pp. 365. (New York: Wm. Wood & Co., April 1881.)

A Medical Formulary based on the United States and British Pharmacopœias, together with numerous French, German and Unofficial Preparations. By Laurence Johnson, A. M., M. D. 8vo. pp. 402. (New York: Wm. Wood & Co., May 1881.)

Clinical Lectures on the Diseases of Old Age. By J. M. Charcot, M. D. Translated by Leigh H. Hunt, B. Sc., M. D., with additional lectures by Alfred L. Loomis, M. D. 8vo. pp. 280. (New York: Wm. Wood & Co., June 1881.)

A System of Surgery, Theoretical and Practical. In Treatises by various authors. Edited by T. Holmes, M. A. Cantab. First American, from second English edition, thoroughly revised and enlarged. By John H. Packard, A. M., M. D., asisted by a large corps of the most eminent American Surgeons. In three volumes, with many illustrations. Vol. II. 8vo. pp. 1063. (Phila: Henry C. Lea's Son & Co., 1881. St. Louis: J. H. Chambers & Co.)

The Opium Habit and Alcoholism. A Treatise on the Habits of Opium and its Compounds; Alcohol; Choral-Hydrate; Chloroform; Bromide of Potassium; and Cannabis Indica, including their Therapeutical Indications, with Suggestions for treating various Painful Complications. By Dr. Fred. Heman Hubbard. 12mo. pp. 259. (New York: A. S. Barnes & Co.) price $2.00

Indigestion and Biliousness. By J. Milner Fothergill, M. D. 8vo. pp. 89. (New York: Bermingham & Co.) price 35 cents. No. 4. Library of Medical Classics, Oct. 15, 1881.

Practical Observations upon Certain Intra-Ocular Affections, Fatal to Vision unless Early Detected and Appropriate Treatment adopted. By Wm. Dickinson, M. D. (Reprint trom *St. Louis Courier of Medicine*, Dec. 1881.)

Ninety-Ninth Annual Catalouge of the Medical School of Harvard University, 1881–1882.

Annual Announcement of the Medical Department of the Minnesota College Hospital, Minneapolis, Minn. 1881–1882.

Bericht über die Dreizehnte Versammlung der Ophthalmologishen Gesellschaft, Heidelberg 1881. Redigirt durch F. C. Donders, W. Hess und W. Zehender. Beilageheft zu den *Klinischen Monats blättern für Augenheilkunde*. XIX Jahrgang 8vo. pp. 199. (Stuttgart: Ferdinand Enke, 1881.)

Sensation and Pain. By Charles Fayette Taylor, M. D. A Lecture delivered before the New York Academy of Science, March 21, 1881; being one of the public course for 1880–81. 24mo. pp. 77. (New York: G. P. Putnam's Sons, 1881. St. Louis: Hugh R. Hildreth Printing Co.) price 75 cents.

Aids to Rational Therapeutics. By J. Milner Fothergill, M. D. M. R. C. P. 32mo. pp. 121. (New York: G. P. Putnam's Sons. 1882. St. Louis: Hugh R. Hildreth Printing Co.) Price paper, 25 cents; cloth, 50 cents.

Address delivered at the dedication of the Hall of the Boston Medical Literary Association, on Dec. 3, 1878. By Oliver Wendell Holmes, M. D., President. Report of C. P. Putnam, M. D., etc. 8vo. pp. 39—18. (Cambridge: Riverside Press. 1881.)

Obstetric and Gynæcological Literature, 1876–1880. By James R. Chadwick, M. D. (Reprinted from the *Boston Medical and Surgical Journal* for Sept. 8, 1881.)

Removal of a Cyst of the Pancreas, weighing Twenty and One-Half Pounds. By Dr. N. Bozeman. (Reprint from the *N. Y. Med. Record* for January 15, 1882.)

Moral (Affective) Insanity. A Plea for its Retention in Medical Nomenclature. By C. H. Hughes, M. D. (Reprint from the *Alienist and Nenrologist*, Jan. 1882.)

Outline Therapeutics of Chronic Alcoholism. By C. H. Hughes, M. D. (Reprint from the *Alienist and Neurologist*, Jan., 1882.)

Aids to Diagnosis. Part III. What to ask. By J. Milner Fothergill, M. D., M. R., C. P. 32mo. pp. 66. (New York: G. P. Putnam's Sons. 1881. St. Louis: H. R. Hildreth Printing Co.,) price 25 cents.

Medizinische Jahrbücher. Herausgegeben von der K. K. Gesellschaft der Ærzte. Redigirt von Prof E. Albert, und Prof. E. Ludwig, Jahergang 1881. II. Heft. 8vo. pp. 290. (Wien: Wilhelm Braumüller. 1881.)

A Case of Prolapse of the Laryngeal Sac. By J. Solis Cohn, M. D. (Reprinted from the *Archives of Laryngology*, January 1882.)

External Perineal Urethrotomy. By Thos. H. Hammond, M. D. (Reprinted from the *Ohio Medical Journal*, January 1882.)

Report on Diphtheria. By Franklin Staples, M. D. 8vo. pp. 44. (Extracted from Annual Report of State Board of Health of Minnesota.)

News Items.

Article XXXVI.

Prospect of A Libel Suit.—Some weeks ago a ripple was created in medical circles by the publication in the New York *Medical Record*, of a statement to the effect that the Illinois State Board of Health had passed a resolution to the effect that the Board would not recognize the diplomas of the College of Physicians and Surgeons of St. Joseph, Mo. Immediately Dr. Geiger, a member of the faculty and secretary of this institution, wrote to the secretary of the Illinois Board, and received the following:

Illinois State Board of Health,
Springfield, Ill., Office of Secretary,
December 23, 1881.

Dr. Jacob Geiger, College Physicians and Surgeons, St Joseph, Mo.—Dear Sir: Yours of the 22d. inst. has been received, and in reply would say that the Board, at its last regular meeting, refused to recognize the diploma of the College of Physicians and Surgeons of Joplin, Mo., and not your College. I do not know how the mistake was made in the New York *Record*. Very Respectfully,

John H. Rauch, M. D., Secretary.

It is said the faculty of the College will demand an explanation at the hands of the editor of the *Medical Record*, and if satisfaction is not obtained in this manner, it is probable that an action will be commenced for libel. The gentlemen of the faculty rank high in the profession, and are all graduates of first class medical colleges. They seem earnest in their efforts to qualify their students for the practice of medicine and surgery, and have received much encouragement at home and abroad. Since the school was chartered, in 1879, it has had one hundred and thirty-four students, twenty-eight of whom have graduated, and now enjoy a lucrative practice. The *Record's* statement will prove alike injurious to the professors in the school, the graduates and the students.

New Journals:

The *Minnesota Medical Mirror* is a monthly of ten pages, which has made its appearance in Cambridge City, Minn. The Editor and Proprietor promises to enlarge it.

The *Medical News and Abstract* has ceased to exist, and its place is supplied by the *Medical News*, a weekly of thirty-two pages. Judging from the initial number, it is destined to spring into popularity at one bound, as it contains good matter and a great deal of it. We suppose Dr. I. Minis Hays is retained as editor.

The *American Medical Digest* is a monthly of forty-eight pages which has just risen above the horizon. It purposes to be similar in aim to the *London Medical Record*, and we hope that it will equal that journal's high standard of excellence. The *Digest* is published by Dr. Jno. C. Lester, at $3.00 per annum. As to its future success, but little can be predicted, as medical literature teems with similar publications, and "the survival of the fittest" will decide the life of each.

Another aspirant for favor is the *American Medical Weekly*, edited and published by Dr. E. S. Gaillard. Formerly the *Bi-weekly*, the publisher has changed its appearance to a weekly of twenty eight pages, and published at the low price of $2.00 per annum. The make-up is the same as that of *Gaillord's Monthly* and it is certainly a cheap medical periodical at the price at which it is now offered.

The Missouri Valley Medical Journal, is a new monthly of fifty-four pages, edited by Drs. W. C. Boteler and F. C. Hoyt, and published at St. Joseph, Mo. It is issued in order "to fill an evident vacancy in this valley, in journalism, and present to the profession, from time to time, an accurate résumé of medical and surgical progress."

The first number of an *Ephemeris of Materia Medica, Pharmacy, Therapeutics and Collateral Information*, has been received. It is a monthly of thirty-two pages, by Edward R. Squibb, M. D., Edward H. Squibb S. B., M. D. and Charles F. Squibb, A. B. The locality of its publication is Brooklyn, N. Y., and it will no doubt prove valuable to manufactueing chemists and pharmacists

We told you so! Brother Gaillard. It seems that your con-

fessional was not exactly what your subscribers desired to contribute to, and so they have left it to languish. They say *peccavi*, but they do not seem to care to say it loud enough for others to hear of it. We were surprised to see that the confessional was "not only closed, but completed!!" (!). But we can bear the loss of this department, as the others have so many good things in them.

Denver is a city which, in the last few years, has grown marvelously and will compare favorably with many cities of a much older and larger growth. It is above all, enterprising, as is evinced by the "annual" of the *Denver Tribune*, which we have received. It is the New Year's supplement, and consists of thirty-two pages, profusely illustrated, and giving a picture of Denver, such as cannot be found in any other periodical. It is a good specimen both of typographical and editorial work It is a complete review of the mining, agricultural and industrial interests of Colorado. All the prominent towns in the State get their share of attention, as also all the counties of the State.

The Black Hills Medical Association held its first annual reunion at Central City on the evening of Jan. 4. The occasion is spoken of as one of general good feeling, and numerous speeches were made. This is the only medical society in Dakota, and its membership at present only includes physicians of Lawrence Co., although not confined to such narrow limits. Dr. Houghton has the honor of being its first president.

The annual election of the St. Louis Medical Society, which took place Jan. 7, resulted as follows;

President: Dr. Wm. Dickinson; Vice-President: Dr. Edw. Borck; Recording Secretary: Dr. A. H. Ohmann-Dumesnil; Corresponding Secretary: Dr. G. F. Dudley; Treasurer: Dr. W. E. Fischel.

It is quite a noticeable fact that the President and Vice-President are specialists, the former being an occulist and the later exclusively devoted to surgery. Verily, the specialist is being noticed in the land.

Hospitals Liable for Malpractice.—It is stated in the *New York Med. Jour.*, that a pay patient of the Rhode Island Hospital sued to recover damages because of a hemorrhage leading to gangrene and amputation, due, it was alleged, to the malprac-

tice of an *interne*. During the suit, the following statement of the legal liabilities of hospitals was made:

1. A hospital is not exempt from liability for unskillfulness or neglect, but is responsible for the exercise of reasonable care by the governing authorities in selecting physicians, surgeons and *internes;* and if incompetent persons are appointed, is responsible for the results of their neglect or want of skill.

2. If the rules of the hospital require that in specified cases an *interne* shall summon an attending surgeon, and the *interne* fail to do so, the corporation may be liable for the consequences of his neglect.—[*Louisville Med. News.*

Cause and Effect.—A lady visiting a friend just confined remarked to the grandmother, "But how small the child is!" The old lady replied, "Well, we had a homœopathic doctor." —[*Cincinnati Enquirer.*

The medical world of Paris is somewhat startled by the report—which unlike most reports, is authentic—that the Minister of the Interior will shortly publish a decree, according to lady medical students the right to compete for the house-surgeonships, hitherto denied to them. The agitation, as is natural, is most marked among the class directly interesed, the house-surgeons. Their concord is not on purely scientific grounds; it is not fear that the medical reputation of their order is in jeopardy. It has another source, which may be described as domestic. What will become of the salle de garde (the dining room and place of reunion)? "Nous ne serons plus chez nous" ("we shall no longer have our house to ourselves)! is the cry. Perhaps M. Quenten, the energetic and amiable head of the Assistance Publique, may solve the difficulty and make life easy to both lady and gentleman house-surgeons by giving them separate salles de garde.—[*British Med. Jour.*

Regulars and Homœopaths in Same Hospital.—The County Hospital (the large public hospital) in Chicago is to be placed in part, under the professional control of the homœopaths—at least it has been so voted by the County Commissioners, which is the governing body of the institution. Only a part of the hospital is to be turned over to the homœopathic profession, the remaining portion, it being intended, shall remain under the present medical management.

The arguments that were considerad by the Commissioners in taking this step were, that a large portion of the taxes were paid by patrons of homœopathy who desired to have that school represented in the hospital management, and that there was reason to hope that under homœopathic management the expenses of the medical department would be reduced. One of the two rival colleges of homœopathy has recently built a college building directly opposite the hospital.—[*N. Y. Med. Record.*

THE VIRCHOW TESTIMONIAL.—The German medical and scientific fraternity, are contributing toward a fund in celebration of the twenty-fifth year of Virchow's professorate, to form a means for the promotion and furtherance of scientific research, bearing especially on the study of man.—[*The Med. and Surg. Reporter.*

THE SMALL-POX.—The tendency of this plague to become epidemic on the Pacific Coast continues to be manifest. Of late the disease has been more common in parts of Washington Territory and Oregon than in California. There can scarcely be a doubt that it would have gained a dangerous foothold in California but for the prompt resort to isolation and vaccination, chiefly adopted through the vigilance of Boards of Health and individual members of the profession.—[*Pacific Med. and Surg. Jour.*

DR. FRANK J. LUTZ, as previously announced in the JOURNAL, went to Columbia to deliver a series of lectures on the surgery of the abdomen. His lectures, thirteen in number, were addressed to the students of the medical department of the State University, and were not only very instructive but very interesting both to the students and professors. Dr. Lutz was well received at the University and by the citizens of Columbia, and he has brought back with him, pleasant reminiscences of that hospitality tended to him. He was also highly gratified at the genial and pleasing manner in which his efforts were received, and altogether he is well pleased with his trip.

METEOROLOGY OF 1881, BY DR. A. WISLIZENUS.

Month.	Therm. F. Mean. of Month.	Date.	Highest Mean.	Date.	Lowest Mean.	Rain and Snow in Inches.
January	20.4 F	30	46.5 F	14	**--7.0 F**	0.45
February	30.9	26	61.5	16	7.0	4.23
March	40.2	24	65.5	5	22.0	1.83
April	52.1	25	85.0	1	25.0	2 77
May	72.0	12	90.5	3	43.5	3.32
June	76.3	16	96.0	22	55.0	2.76
July	80.5	10	101.5	1	63.5	1.65
August	83.5	12	**104 0**	15	65.5	0.24
September	76.7	5	100.0	16	50.5	3.08
October	62.5	8	85.5	20	43.5	7.13
November	43.0	1	69.5	24	16.5	5.33
December	40.8	12	61.5	30	18.0	1.48

Year's mean temp. 56.7 — Total quantity of rain and snow, 34.27

For comparison I add here the mean temperature and quantity of rain in St. Louis from Dr. Engelmann's observations for thirty years :

	Jan.	Feb.	March	April	May	June	July	Aug.	Sept.	Oct.	Nov.	Dec.	Year.
Mean temp. F.	32.4	35.3	44.4	56.1	66.3	74.4	79.0	76.5	69.4	55.8	43.4	33.8	53.6
Quantity of rain	2.14	2.66	3.81	3.96	4.94	5.66	4.17	4.15	3.25	3.39	3.16	3.16	44.46

REMARKS.

Our climate in the centre of the Mississippi Valley is justly called an excessive one. As in the different seasons we often suffer from the extreme cold or heat, so the different years exhibit sometimes a surprising irregularity, from which only in the lapse of ten or more years, a mean regularity and normal constant can be deduced. As such a year of great irregularity, we must consider the past one of 1881. The beginning of the year coincided nearly with the middle of the most obstinately severe winter I have experienced in St. Louis, that began in November and December of 1880, and was continued for three months longer in 1881. The mean temperature of the first four months of the year 1881, was therefore far below the normal one; while the normal temperature of these four months amounts to 168.2 degrees Fahr., it reached in the year 1881, 143.5, or 24.6 less. Consequently the spring was late and short. Vegetation was delayed about a month. Many fruit trees were killed by frost. But in May the whole scene was changed. From May up to the end of the year the repressed heat of the sun did its utmost to make up for the lost time. While the normal mean temperature for these eight months is 498.6 degrees F., it rose now to 535.4 or 37.7 more than the mean. This considerable and sudden increase of temperature would not have acted so injuriously on vegetation, had it been accompanied by corresponding rains. But these precipitations of moisture occurred very sparingly and were very unequally distributed. The quantity of rain during the whole year of 1881 (34.27 inches) was about ten inches less than the normal mean one, (which is 44.45 inches). The four months from May to Augnst, during which about nineteen inches of rain fall usually, showed only a rainfall of about eight inches, and in the uncommonly hot month of August, only a quarter of an inch was precipitated The effect of this excessive heat and drought was most destructive to crops. Vegetables and corn dried up, fruit fell unripe from the trees. The vineyards only, in which on accounnt of the dryness, no rot was developed, yielded a moderate return. From the end of September until November, considerable quantities of rain fell at last, about fifteen and a half inches, but too late in the season to do much good for this year.

The fall was on the whole very pleasant, and December so mild that it represented our "Indian summer," more than a winter month. Our winter has apparently adjourned till after New Year, and will in all probability be much shorter and milder than the last.

METEOROLOGICAL OBSERVATIONS.

By A. WISLIZENUS, M. D.

The following observations of daily temperature in St. Louis are made with a MAXIMUM and MINIMUM thermometer (of Green, N. Y.). The daily minimum occurs generally in night, the maximum at p. m. The monthly mean of the daily minima and maxima added and divided by two, gives quite a reliable mean of the monthly temperature.

THERMOMETER, FAHRENHEIT—DEC., 1881.

Day of Month.	Minimum.	Maximum.	Day of Month	Minimum.	Maximum.
1	34.0	43.0	18	40.0	53.5
2	32.5	41.5	19	42.0	58.5
3	40.0	43.5	20	48.5	52.5
4	38.0	39.5	21	46.0	51 5
5	30.0	40.5	22	32.5	43.5
6	39.0	54.0	23	37.0	40.5
7	32.5	39.5	24	31.5	40.0
8	34.5	51.0	25	34.5	47.5
9	36.5	42.0	26	36.5	49.0
10	29.0	40.0	27	37.5	42.5
11	34.0	40.0	28	39.5	56.5
12	43.0	**61.5**	29	36.0	43.5
13	55.0	61.0	30	**18.0**	28.0
14	30.0	38.0	31	25.0	30.5
15	29.0	42.5			
16	33.5	49.0	Means	35.8	45.8
17	37.5	52.5	Monthly Mean.	40 8	

Quantity of rain and snow, 1.48 inches.

MORTALITY REPORT.---CITY OF ST. LOUIS.

FROM NOV. 5, 1881, TO NOV. 26, 1881, INCLUSIVE.

Small Pox..... 0	Childbirth..... 12	Convulsions & Trismus Neonatorum 39	Syphilis..... 3
Scarlatina. 10	Inanition, Want of Breast Milk.etc. 12	Hydrocephalus and Tub. Meningitis. 6	Apoplexy 12
Pyæmia & Septicæ 5	Alcoholism.. 5	Meningitis & Encephalitis 12	Dis. fem. gen. org. 1
Erysipelas 0	Rheumat'm & Gout 0	Other Diseases of the Brain and Nervous System22	Surgical Operation 0
Diphtheria 22	Cancer and Malignant Tumor..... 12	Cirrhosis of Liver and Hepatitis ...22	Premature Birth 0
Membran's Croup. 8	Phthisis & Tuberculosis, Pulmon 17	Enteritis, Gastro-Enteritis, Peritonit, and Gastritis' 20	Deaths by Suicide 23
Whooping Cough. 2	Bronchitis.. 8	Bright's Disease and Nephritis... 8	Deaths by Accid't 1
Ovarian tumor.... 0	Senility 14	Other Diseases of Urin ary Organs. 1	Deaths by Homicid 4
Measles 1	Pneumonia.....40	Diabetes..... 0	Congen Detor'ty 26
Typhoid Fever....32	Heart Diseases ...27		Total Deaths from all Causes 631
Cerebro Spinal Fev 2	Other Diseases of Respir'y Organs 8		Total Zymotic Diseases 201
Remittent, Intermittent, Typho-Malarial, Congestive & Simple	Heat Stroke..... 0		Total Constitutional Diseases.....141
Contin'd Fevers,44	Marasmus — Tabes Mesenterica and Scrofula. 27		Total Local Diseases 220
Puerperal Fevers.. 1	Other Const. Dis 8		Total Develop'tal Diseases 41
Diarrhœal Disea's 48			Deaths by Viol'ce28
Other Zymotic Diseases 6			

CHAS. W. FRANCIS, *Health Commissioner.*

FELLOWS' HYPO-PHOS-PHITES

Contains **THE ESSENTIAL ELEMENTS** to the Animal Organization—
Potash and Lime;

The **OXYDIZING AGENTS**—Iron and Manganese;

The **TONICS**—Quinine and Strychnine;

And the **VITALIZING CONSTITUENT**—Phosphorus,
Combined in the form of a Syrup, with *slight alkaline reaction.*

IT DIFFERS IN EFFECT FROM ALL OTHERS, being pleasant to taste, acceptable to the stomach, and harmless under prolonged use.

IT HAS SUSTAINED A HIGH REPUTATION in America and England for efficiency in the treatment of Pulmonary Tuberculosis, Chronic Bronchitis, and other affections of the respiratory organs, and is employed also in various nervous and debilitating diseases with success.

ITS CURATIVE PROPERTIES are largely attributable to Stimulant, Tonic, and Nutritive qualities, whereby the varions organic functions are recruited.

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THE PRESCRIBED DOSE produces a feeling of buoyancy, removing depression or melancholy, and hence is of great value in the treatment of **mental and nervous affections.**

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Recent Introduction to the Materia Medica.

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CHEKEN. (*Eugenia Cheken, Myrtus Chekan.*) This remedy, a native of Chili, is very popular in that country, where it is employed as an *inhalation* in diphtheria, laryngitis, bronchitis, bronchorrhœa, etc.; as an *injection* in gonorrhœa, leucorrhœa, cystitis, etc.; and *internally* as an aid to digestion, to allay cough, to facilitate expectoration and to stimulate the kidneys. It is also an astringent and is said to be of great value in hæmoptysis.

Cheken (known also as Chekan and Chequen), was introduced to the profession of England through a report of results following its use in chronic bronchitis or winter cough by Wm. Murrell, M. D., M. R. C. P., Assistant Physician to the Royal Hospital for Diseases of the Chest, and Lecturer on Practical Physiology at the Westminster Hospital. Dr. Murrel's report is very favorable and he has supplemented it by private advices to us expressing great satisfaction with the drug in the affections in which he has employed it. He regards it as one of the most valuable introductions of late years and pronounces it a drug of very superior properties in the treatment of **chronic bronchitis**, acting in this affection both as an anodyne and exerting a favorable influence over the organic changes in the mucous membrane. It is certainly a remedy which merits a thorough trial at the hands of the profession of this country.

SIERRA SALVIA. ("MOUNTAIN SAGE.") *Artemisia Frigida.* Fluid extract of the herb. Dose one to two fluid-drachms. **Diaphoretic and diuretic.**

The success which has attended the administration of this drug in "Mountain fever" has suggested its employment in all febrile conditions attended with suppression of the secretions of the skin and kidneys. Its action in fever seems to be two-fold, acting directly on the nervous centre, thus inducing a direct lowering of the temperature, and facilitating the radiation of the heat through diaphoresis which it stimulates. Under its use, the kidneys are also aroused to activity, and the solid constituents of the urine proportionately increased. Therapeutic tests have corroborated the opinion formed of it on theoretical grounds.

PERSEA. (ALLIGATOR PEAR.) Fluid extract of the seeds. Dose 30 to 60 minims. This remedy is now for the first time presented to the profession of this country. It is introduced on the recommendation of Dr. Henry Froehling, of Baltimore, Maryland, who, while acting in the capacity of botanist and scientist to an exploring expedition in Southern Mexico, became familiar with the drug, both from reports of the natives and personal experience, as a remedy in **intercostal neuralgia**. The following extract from Dr. Froehling's report will give some conception of the future of this remedy:

"A common experience among physicians is that some cases of intercostal neuralgia are very troublesome and obstinate, resisting almost every kind of treatment; particularly is this the case in malarial districts. In such cases I would recommend the fluid extract of Persea seed. In my own person and in every case in which I have employed it I have been highly gratified with the result. Those of my medical friends to whom I have given samples of the preparation warmly endorse my opinion of it as above and I cannot but believe that further trial of it will cause it to be regarded as a valuable addition to our list of medicines."

Dr. Froehling also mentions the fact that Persea has been employed with benefit in the expulsion of tapeworm.

COCA. (ERYTHROXYLON COCA.) The evidence in favor of Coca is to prove it a powerful nervous stimulant, through which property it retards waste of tissue, increases muscular strength and endurance and removes fatigue and languor, due to prolonged physical or mental effort. While indicated in all conditions presenting these symptoms it has an especial indication in the treatment of **the opium and alcohol habits.** In these deplorable conditions it has been found to possess extraordinary properties—relieving the sense of untold bodily and mental misery which follows the withdrawal of the accustomed stimulus, thus preventing a return to the narcotic, and affording an opportunity for building up the system by the administration of restorative tonics.

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